BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	No. 16-96-62726
AUGUST L. STEMMER, M.D. 118 Post Street Petaluma, California 94952	OAH No. N-9609085
Physician's and Surgeon's Certificate No. G6854,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on January 16, 1997.

IT IS SO ORDERED December 17, 1996.

ANABEL ANDERSON IMBERT, M.D.
Chair, Panel B

OAH 15 (Rev. 6/84)

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: AUGUST L. STEMMER, M.D. 118 Post Street Petaluma, California 94952 Physician's and Surgeon's Certificate No. G6854, Respondent.	No. 16-96-62726 OAH No. N-9609085

PROPOSED DECISION

The matter came on regularly for hearing before Jaime René Román, Administrative Law Judge, Medical Quality Hearing Panel, Office of Administrative Hearings, Sacramento, California, on November 14, 1996.

Complainant was represented by Fred A. Slimp, II, Deputy Attorney General, Health Quality Enforcement Section, California Department of Justice.

Respondent August L. Stemmer, M.D. (hereinafter "Respondent") was represented by Kenneth A. Coren, Esq.

Evidence was received and the matter deemed submitted on November 14, 1996.

FINDINGS OF FACT

Procedural Findings

I

Complainant, Ronald Joseph, Executive Director of the Medical Board of California (hereinafter "the Board"), brought the Accusation on August 26, 1996, in his official capacity.

II

On June 13, 1961, Respondent was issued Physician's and Surgeon's Certificate No. G6854 by the Board.

Factual Findings

III

In 1955, Respondent graduated from Harvard University Dental School with a D.M.D. degree. Following graduation, and incident to a particular program extant at that time, Respondent enrolled in and graduated from Harvard University Medical School with an M.D. degree in 1957. Following an internship and residency, and having been deferred from military service during his period of education and training, he entered the United States Army. Having been certified by the American Board of Otolaryngology, Respondent, in 1961, upon departing the Army, entered into a private practice involving Otolaryngology and Maxillo-Facial Surgery in San Francisco. In early 1971, having been offered an appointment at Illinois' Cook County Hospital, he departed California and, obtaining appropriate licensure in Illinois, undertook duties as Chief, Otolaryngology and Maxillo-Facial Surgery, including teaching twelve residents. Departing Illinois in 1975, he returned to a private practice in Otolaryngology and Maxillo-Facial Surgery in San Francisco until around 1978 or 1979. Thereafter he departed San Francisco to undertake a similar private practice in Lake Tahoe.

IV

At the onset of Operation Desert Storm, and as a consequence of the bankruptcy of the hospital in Lake Tahoe, requiring Respondent to travel some distance to exercise surgical and hospital privileges, and, 62 years old, he considered the significance of a retirement pension, and solicited both the Navy and the Army for appointment as a commissioned medical officer. Respondent selected the Army and, in April 1991, undertook duties in Germany as a commissioned medical officer at the rank of Major.

V

As a consequence of Operation Desert Storm, and casualties related thereto, Respondent, practicing Otolaryngology and Maxillo-Facial Surgery, would see 5 - 10 patients a day. Military downsizing and fiscal constraints by 1993 increased the number of patients he would see to at least 10 - 20 patients a day. By 1994, the patient load increased even further.

VI

Sometime in 1993, Respondent, engaged in the treatment of patients as referenced in Finding No. V, noticed an increasing daily lassitude and visual acuity problem. Following numerous visits, he was referred to an Opthamologist who diagnosed cataracts. Further referral resulted in an additional diagnosis of diabetes.

VII

On February 23, 1995, following a hearing, Respondent's clinical privileges in Otolaryngology and Maxillo-Facial Surgery at Landstuhl Medical Center, Germany, were revoked. Respondent appealed the revocation and, on November 22, 1995, the Department of the Army, Office of the Surgeon General, upheld the revocation.

VIII

The facts and circumstances underlying the discipline set forth in Finding No. VII are that Respondent:

A. Consistently failed to examine patients to the degree appropriately indicated by presenting complaint and/or consultation requested.

B. Failed to employ a surgical methodology in concert with currently accepted otolaryngology technology.

C. Consistently failed to appropriately document patient histories, physical examinations and operative reports to the degree generally acknowledged as being appropriate standard of practice.

D. Consistently failed to exercise proper judgment in the course of patient care management.

IX

Claiming to the Army that the circumstances referenced in Finding No. V impeded his ability to competently practice, the Army found that:

A. He had failed to substantiate that his shortcomings in clinical practice are a result of the pressures of large patient backlogs and the access to care requirements of the "3/10 day access standard."

B. Other staff otolaryngologists, faced with the same requirements, were able to see even more patients than Respondent while consistently demonstrating appropriate clinical management and documentation.

Circumstances in Mitigation

X

Respondent, 67, licensed to practice medicine in California for 35 years, has never been disciplined by the Board.

XI

Respondent, a Lieutenant Colonel and presently affiliated with the Army Reserves, readily acknowledges the discipline imposed by the Army.

XII

Respondent submitted letters of reference relating to his competency to practice. These letters, drafted in 1994 and antedating the discipline imposed as set forth in Finding No. VII, have been given no weight by this tribunal. In the Matter of Brazil (1994) 2 Cal. State Bar Ct. Rptr. 679; In the Matter of Respondent K (1993) 2 Cal. State Bar Ct. Rptr. 335; In the Matter of Potack (1991) 1 Cal. State Bar Ct. Rptr. 525; In the Matter of Katz (1991) 1 Cal. State Bar Ct. Rptr. 502.

XIII

Respondent has been successfully treated for his cataracts and diabetes.

Circumstances in Aggravation

XIV

The discipline imposed on Respondent by the Army as set forth in Finding Nos. VII - VIII is less than two years old.

XV

Respondent's Board certification does not require re-certification as a measure of continuing competency.

XVI

Respondent, notwithstanding a successful professional career, was clearly unprepared for the rigors of practice in the

Army. Respondent's repeated failures to meet the standard of care as set forth in Finding No. VIII evince a lack of circumspection and questionable continuing competency.

Costs Findings

XVII

The Board incurred $831.25 as reasonable costs and fees in the investigation and prosecution of this matter.

DETERMINATION OF ISSUES

I

Cause exists to revoke or suspend the certificate of Respondent as a physician and surgeon for discipline imposed by another state pursuant to the provisions of Business and Professions Code §141 as set forth in Finding Nos. II and VII - VIII. (Marek v. Board of Podiatric Medicine (1993) 16 Cal.App.4th 1089, 10093.)

II

Cause exists to direct Respondent to pay $831.25 as costs in the investigation, prosecution or enforcement of this matter pursuant to Business and Professions Code §125.3 as set forth in Finding No. XVII.

III

The objective of this proceeding is to protect the public, the medical profession, maintain professional integrity, its high standards, and preserve public confidence in the medical profession. These proceedings are not for the primary purpose of punishing an individual (Camacho v. Youde (1979) 95 Cal.App.3d 161, 165; Fahmy v. Medical Board of California (1995) 38 Cal.App.4th 810, 816), including Respondent.

Licensure by the Board is not readily granted. Qualification for licensure must be met (Business and Professions Code section 2080, et seq.) and minimum standards continuously maintained (Business and Professions Code section 2190, et seq.). The effect of state licensure in California is to assure the public that the person holding the license is qualified. This furthers the state's interest in public health, safety, moral and welfare. This, however, places a burden not merely on the state but also Respondent to responsibly conduct **all** his affairs. In this regard, it is Respondent who, in the responsible conduct of his affairs, furthers public confidence in licensure.

The key concern in arriving at a disciplinary recommendation is the degree to which the public needs protection from Respondent. (Mepham v. State Bar (1986) 42 Cal.3d 943, 948; In the Matter of Rodriguez (1993) 2 Cal. State Bar Ct. Rptr. 480, 501.)

Consideration of Respondent's basis for misconduct (Finding Nos. VII - VIII) must be balanced with factors relating to mitigation and rehabilitation (Finding Nos. X - XII) and aggravation (Finding Nos. XIV - XVI) to determine the proper meting of discipline. (Cf. In the Matter of Taylor (1991) 1 Cal. State Bar Ct. Rptr. 563, 580; Snyder v. State Bar (1990) 49 Cal.3d 1302, 1310 - 1311.) Of particular import is the length of time in which this licensee has practiced without Board disciplinary incident (Finding No. X) balanced, however, against the apparent lack of pertinent continuing and current medical education and training (Finding Nos. XV - XVI) notwithstanding Board certification (Finding No. III).

Accordingly, giving due consideration to the facts underlying the Accusation (Finding Nos. II - IX), the evidence of mitigation and rehabilitation (Finding Nos. X - XII) and aggravation (Finding Nos. XIV - XVI), the public interest will not be adversely affected by the continued issuance of a properly conditioned physician's and surgeon's certificate to Respondent.

ORDER

Certificate No. G6854 issued to Respondent August L. Stemmer, M.D., is revoked; provided, however, said revocation is stayed and Respondent is placed on probation pursuant to Determination of Issues No. I for a period of five (5) years on the following terms and conditions:

1. Within fifteen (15) days of the effective date of this Decision, and during the period of probation, Respondent shall provide the Division of Medical Quality or its designee, proof that Respondent has provided a true copy of this Decision on the Chief of Staff or the Chief Executive Officer at every hospital, medical group or other facility or association where privileges or membership are extended to Respondent or where Respondent is employed to practice medicine and on the Chief Executive Officer of every insurance carrier where malpractice insurance coverage is extended to Respondent or where compensation is tendered for medical services rendered by Respondent.

2. Within sixty (60) days of the effective date of this Decision, Respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

3. Within sixty (60) days of the effective date of this Decision, Respondent shall pay $831.25 to the Division of Medical Quality or its designee as costs in the investigation, prosecution and enforcement. Failure to reimburse the Division's cost of its investigation and prosecution shall constitute a violation of probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship.

4. Within sixty (60) days of the effective date of this Decision and prior to engaging in the practice of Otolaryngology and Maxillo-Facial Surgery, Respondent shall submit to the Division of Medical Quality or its designee for its prior approval a plan of practice in which Respondent's practice, for the first two years following successful completion of the oral clinical examination requirement, shall be monitored by another physician in Respondent's field of practice, who shall provide periodic reports to the Division or its designee. If the monitor resigns or is no longer available, Respondent shall, within fifteen (15) days, move to have a new monitor appointed, through nomination by Respondent and approval by the Division or its designee. Respondent is prohibited from engaging in solo practice for compensation.

5. Within ninety (90) days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Division of Medical Quality or its designee for its prior approval an educational program or course in Otolaryngology and Maxillo-Facial Surgery which shall not be less than 40 hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division or its designee.

6. Respondent, at his expense, shall take and pass an oral clinical examination in Otolaryngology and Maxillo-Facial Surgery. This examination shall be taken within ninety (90) days after the effective date of this Decision. If Respondent fails the first examination, Respondent shall be allowed to take and pass a second examination, which may consist of a written as well as an oral examination. The waiting period between the first and second examinations shall be at least three (3) months. If Respondent fails to pass the first examination, he shall notify the American Board of Otolaryngology within ten (10) days of such failure. If Respondent fails to pass the first and second examinations, he may take a third and final examination after waiting a period of one year. Failure to pass the oral clinical examination within 18 months after the effective date of this Decision shall constitute a violation of probation.

Respondent shall not practice Otolaryngology and Maxillo-Facial Surgery until he has passed the required examination and has been so notified by the Division of Medical Quality or its designee in writing. This prohibition shall not bar Respondent from practicing in a clinical training program approved by the Division or its designee and is restricted only to that which is required by such approved training program.

7. Within ninety (90) days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Division of Medical Quality or its designee, Respondent, at his expense, shall undergo a medical evaluation by a Division-appointed physician who shall furnish a medical report to the Division or its designee. If Respondent is required by the Division or its designee to undergo medical treatment, Respondent shall, within thirty (30) days of the requirement notice, submit to the Division or its designee for its prior approval the name and qualifications of a physician of Respondent's choice. Upon approval of the treating physician, Respondent shall undergo and continue medical treatment until further notice from the Division or its designee. Respondent shall have the treating physician submit quarterly reports to the Division or its designee indicating whether Respondent is capable of practicing medicine safely.

8. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

9. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division of Medical Quality, stating whether there has been compliance with all the conditions of probation.

10. Respondent shall comply with the Division of Medical Quality's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record. Respondent shall also immediately inform the Division or its designee, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 days.

11. Respondent shall, at her expense, appear in person for interviews with the Division of Medical Quality, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

12. Respondent is ordered to reimburse the Division of Medical Quality the reasonable monthly costs incurred in the administration of probation herein.

13. In the event Respondent should leave California to reside or practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the Division of Medical Quality or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty (30) days in which Respondent is not engaging in any activities defined in Business and Professions Code section 2051 and 2052. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California

or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

14. Upon successful completion of probation, Respondent's certificate will be fully granted.

15. If Respondent violates probation in any respect, the Division of Medical Quality, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation or Petition to Revoke Probation is filed against Respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

Dated: November 18, 1996

JAIME RENÉ ROMAN
Administrative Law Judge
Medical Quality Hearing Panel
Office of Administrative Hearings

REDACTED

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: AUGUST L. STEMMER, M.D. 118 Post Street Petaluma, California 94952 California Physician's and Surgeon's Certificate No. G6854 Respondent.	Case No. 16-96-62726 **ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant, Ronald Joseph, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about June 13, 1961, Physician's and Surgeon's Certificate No. G6854 was issued by the Board to August L. Stemmer M.D. (hereinafter "respondent"), and at all times relevant to the charges brought herein, this license has been in

full force and effect. Unless renewed, it will expire on March 31, 1997.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Section 2227 of the Code provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 125.3 of the Code provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

C. Section 118(b) of the Code provides, in part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the time within which the license may be renewed, restored, or reinstated.

D. Section 2428 of the Code provides, in part, that a license which has expired may be renewed any time within five years after expiration.

//

E. Section 141 of the Code provides:

"(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

FIRST CAUSE FOR DISCIPLINE

(Discipline Imposed By A Federal Governmental Agency)

4. Respondent Stemmer is subject to disciplinary action under section 141 of the Business and Professions Code in that on February 23, 1995, the Department of the Army, Landstuhl Army Medical Center imposed discipline on respondent's license to practice medicine in the Army by permanently revoking

respondent's clinical privileges in otolaryngology and maxillo-facial surgery at Landstuhl Regional Medical Center, Germany. Respondent appealed that revocation. On November 22, 1995, the Department of the Army, Office of the Surgeon General upheld that revocation. The Department of the Army found that respondent was not competent to practice medicine in his assigned specialty of otolaryngology and maxillo-facial surgery as follows:

A. Respondent had consistently failed to examine patients to the degree appropriately indicated by presenting complaint and/or consultation.

B. Respondent's surgical methodology is not in concert with currently accepted otolaryngology technology.

C. Respondent had consistently failed to document patient histories, physical examinations and operative reports appropriately and to the degree generally acknowledged as being appropriate standard of practice.

D. Respondent had consistently failed to exercise proper judgment in the course of patient care management.

E. Respondent had failed to substantiate his suggestion that his shortcomings in clinical practice are a result of the pressures of large patient backlogs and the access to care requirements.

Attached as Exhibit A and incorporated by reference is a true and copy of the Decision from the Department of the Army.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G6854, heretofore issued to respondent August L. Stemmer, M.D.;

2. Revoking, suspending or denying approval of the respondent's authority to supervise physician's assistants, pursuant to Business and Professions Code section 3527;

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case;

4. Taking such other and further action as the Division deems necessary and proper.

DATED: August 26, 1996

RONALD JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

03573160-
SA96AD0971
(SM 8/7/96)

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

NOV 2 2 1995

REPLY TO
ATTENTION OF

Deputy Surgeon General

Quality Assurance Document
10 USC 1102, Unauthorized
Disclosure carries $3000 Fine

Lieutenant Colonel August Stemmer
Landstuhl Regional Medical Center
CMR 402
APO AE 09180-3460

Dear Colonel Stemmer:

Your appeal of the decision by the Commanding General, U.S. Army Medical Command and the Commander, Landstuhl Army Medical Center, Germany to revoke your clinical privileges has been thoroughly and completely reviewed.

After very careful consideration of the entire record to include those matters you have brought to my attention in your appeal, I deny your request regarding the revocation of your clinical privileges.

Under the provisions of Army Regulation 40-68, this is the final action in the appeals process.

Sincerely,

[redacted]

Major General, U.S. Army
Deputy Surgeon General

Copies Furnished:

Commander, U.S. Army Medical Command, ATTN: MCHO-CL-Q,
2050 Worth Road, Fort Sam Houston, Texas 78234-6000
Commander, Landstuhl Army Regional Medical Center,
CMR 402, APO AE 09180-3460

TRUE CERTIFIED COPIES

BY _____

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

May 30, 1995

REPLY TO
ATTENTION OF

Clinical Operations

**Quality Assurance Document
10 USC 1102, Unauthorized
Disclosure carries $3000 Fine**

Lieutenant Colonel August Stemmer
Landstuhl Regional Medical Center
CMR 402
APO AE 09180

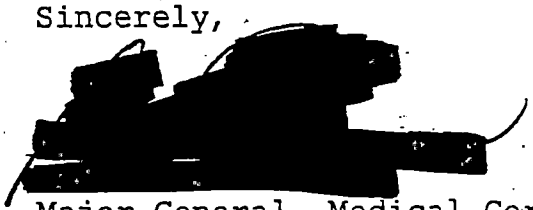
Dear Colonel Stemmer:

The U.S. Army Medical Command Appeals Committee met on May 1, 1995, pursuant to Army Regulation 40-68, paragraph 4-10, to consider your appeal of the action taken by the Commander, Landstuhl Army Medical Center, Germany to the revocation of your clinical privileges.

I deny your appeal regarding the revocation of your clinical privileges. I reviewed your commander's action and the recommendations of the Appeals Committee. After careful consideration of all the facts, I feel that there is sufficient evidence to uphold the action of the Commander, Landstuhl Army Medical Center, Germany.

You may appeal my decision to the Office of The Surgeon General, Department of the Army, within 10 duty days after you receive notice of this action. Your written appeal must be sent by certified mail to: U.S. Army Medical Command, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, Texas 78234-6000. The Surgeon General is the final appellate authority for adverse clinical privileging actions.

Sincerely,



Major General, Medical Corps
Deputy Commanding General

stemmer.app

TRUE CERTIFIED COPIES

BY

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA

23 February 1995

MEMORANDUM THRU

Deputy Commander for Clinical Services, LRMC, APO AE 09180

Chief, Department of Surgery, LRMC, APO AE 09180

FOR LTC August Stemmer, MC, [redacted]

SUBJECT: Commander's Decision, Clinical Privileges

1. On 13 January 1995, a Credentials Hearing Committee convened, at your request, to hear and review evidence presented by witnesses called by the Hearing Committee and to review evidence and hear testimony presented by you and on your behalf, concerning my decision to revoke your clinical privileges to practice medicine and surgery in the specialty of otolaryngology and maxillo-facial surgery.

2. The findings, conclusions and recommendations of the Hearing Committee were presented to me for decision. Based on the recommendations of the Hearing Committee, and after review for legal sufficiency by the Office of the Judge Advocate, I have made a final decision as to the disposition of your clinical privileges.

3. You are hereby notified that I have permanently revoked your clinical privileges in otolaryngology and maxillo-facial surgery at Landstuhl Regional Medical Center.

4. In accordance with AR 40-68, paragraph 4-10, you have a right to appeal my decision to the Commander, US Army Medical Command, 2050 Worth Road, Fort Sam Houston, Texas 78234-6000. You have 10 duty days from the date of this letter to provide written notification to the Commander, US Army Medical Command, of your desire to appeal. Failure to appeal within the prescribed time period, absent good cause, constitutes a waiver of your rights to appeal. The final decision on your privileging may be reported to the National Practitioner Data Bank (NPDB) as determined by the U.S. Army Surgeon General.

[redacted]

COL, MC
Commanding

TRUE CERTIFIED COPIES
BY

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

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AEMLA

MEMORABDUM FOR Commander, LRMC

SUBJECT: Acknowledgement of Status of Clinical Privileges

1. Reference letter AEMLA, dated 23 February 1995, Subject: Commander's Decision, Clinical Privileges.

2. Receipt is acknowledged this date of the above referenced letter. I understand the content of the Commander's decision and am advised that should I decide to appeal his decision, I have ten {10} duty days from the date I acknowledged receipt of this letter in which to provide written request of appeal to the Commander, U.S. Army Medical Command, in accordance with AR 40-68.

Date Acknowledged: 23Feb95

AUGUST L. STEMMER
LTC, MC
[redacted]

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BY

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

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AEMLA-DCCS

18 January 1995

MEMORANDUM FOR Commander LRMC

SUBJECT: Credentials Hearing Committee Findings and Recommendations, LTC August Stemmer, MC

1. The LRMC Credentials Committee, duly appointed to serve in the capacity of Credentials Hearing Committee IAW AR 40-68, to hear the case of LTC August Stemmer, MC, [redacted] met at 0900 hours on 13 January 1995. The hearing was conducted to hear LTC Stemmer regarding an adverse privileging action which was taken to revoke his clinical privileges to practice in otolaryngology and maxillo-facial surgery at LRMC. A summary record of the hearing proceedings has been prepared and accompanies this memorandum.

2. Evidence was presented, witnesses were heard, and after due deliberation, the following findings conclusion and recommendations were reached:

a. Findings:

(1) That LTC August Stemmer has consistantly failed to examine patients to the degree appropriately indicated by presenting complaint and/or consultation request;

(2) That LTC August Stemmer's surgical methodology is not in concert with currently accepted otolaryngology technology;

(3) That LTC August Stemmer has consistantly failed to document patient histories, physical examinations and operative reports appropriately and to the degree generally acknowledged as being appropriate standard of practice;

(4) That LTC August Stemmer has consistantly failed to exercise proper judgement in the course of patient care management;

(5) That LTC August Stemmer has failed to substantiate his suggestion that his shortcomings in clinical practice are a result of the pressures of large patient backlogs and the access to care requirements of the "3/10 day access standard" as other staff otolaryngologists, faced with the same requirements, were able to see even more patients than LTC Stemmer while consistantly demonstrating appropriate clinical management and documentation.

CONFIDENTIAL QA DOCUMENT
DISCLOSURE PROHIBITED IAW TITLE 10 U.S.C., SECTION 1102(b)

TRUE CERTIFIED COPIES
BY

c. Conclusion: The Hearing Committee concluded that LTC August Stemmer, MC, is not competent to practice medicine in his assigned specialty of otolaryngology and maxillo-facial surgery at Landstuhl Regional Medical Center.

b. Recommendations: The Hearing Committee recommends that LTC August Stemmer's clinical privileges in otolaryngology and maxillo-facial surgery remain permanently revoked.

Encl: as

[redacted]
COL, MC
Chairman

Quality Assurance Document
10 USC 1102, Unauthorized
Disclosure carries $3000 Fine

CONFIDENTIAL QA DOCUMENT
DISCLOSURE PROHIBITED IAW TITLE 10 U.S.C., SECTION 1102(b)

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BY

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

18 January 1995

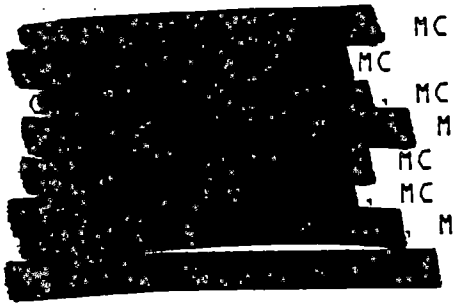
AEMLA-QA

MEMORANDUM FOR Commander, Landstuhl Regional Medical Center

SUBJECT: Summary Record of Credentials Hearing Committee, LTC August Stemmer, MC, [redacted]

1. In accordance with the provisions of AR 40-68, Quality Assurance Administration, paragraph 4-9, a hearing was convened on 13 January 1995 at 0908 hours in the DCCS Conference Room, Landstuhl Regional Medical Center. The hearing was called at the request of LTC August Stemmer, MC, in response to revocation of his clinical privileges in Otolaryngology and Maxillo-Facial Surgery placed in effect on 2 November 1994.

2. VOTING MEMBERS PRESENT:



[redacted] MC — Chairman
[redacted] MC — Member
[redacted] MC — Member
[redacted] MC [USAF] — Member
[redacted] MC — Member
[redacted] MC — Member
[redacted] MC — Member
[redacted] MC — Member

3. NON-VOTING MEMBERS PRESENT:

[redacted] MC [USAF] Chief, Otolaryngology, Bitburg A Hospital, Germany, Specialty Expert Consultant to the Hearin Committee

LTC August Stemmer, MC, Respondent
[redacted], LRMC Medical Claims JAG
[redacted] Trial Defense Counsel [Assisting LTC Stemmer]
[redacted], Recorder

4. PURPOSE: This hearing was convened for the purpose of hearing LT August Stemmer, MC, regarding the allegations of inappropriat clinical practice which led to his privileges at LRMC being revoked c 2 November 1994. The evidence which led to the revocation c privileges was reviewed, witnesses were heard and evidence wa presented by LTC Stemmer on his behalf.

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5. PROCEEDINGS:

a. [redacted], MC, Chairman, called the hearing to orde at 0908 hours on 13 January 1995, in the LRMC DCCS Conference Room Attendance was noted as documented in paragraph 2 and 3 above. Thos in attendance were introduced to include reason for attendance a follows:

{1} [redacted], MC, Hearing Committee Chairman, LRMC DCC and General Surgeon.

{2} [redacted], MC, Hearing Committee Member and Chief Department of Radiology at LRMC.

{3} [redacted] MC, Hearing Committee Member and Chief Department of Psychiatry at LRMC.

{4} [redacted] MC, USAF, Hearing Committee Member ar Chief, Department of Pediatrics and Neonatology at LRMC.

{5} [redacted] MC, Hearing Committee Member and Chie Department of Surgery at LRMC.

{6} [redacted] MC, Hearing Committee Member and Chie Department of Pathology and Area Laboratory at LRMC.

{7} [redacted] MC, Hearing Committee Member and Chie department of Obstetrics and Gynecology at LRMC.

{8} [redacted] MC, Hearing Committee Member and Chie Department of Ambulatory Patient Care at LRMC.

{9} [redacted] MC, Specialty Advisor to the Hearl Committee and Chief, Otolaryngology at Bitburg USAF Hospital, Germar

{10} LTC August Stemmer, MC, Respondent.

{11} [redacted] LRMC Medical Claims JAG and Legal Advis to the Hearing Committee.

{12} [redacted] Kaiserslautern Area Defense Counsel legal advisor to LTC Stemmer.

{13} [redacted], Recorder

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b. The Chairman informed LTC Stemmer that the hearing was be conducted at his request and that the purpose was to consi documentary evidence and witness testimony relating to LTC Stemme competence to practice medicine, specifically in the field

Otolaryngology and Maxillo-Facial Surgery. LTC Stemmer was also advised that the Hearing Committee will reach conclusions and make recommendations to the Commander, Landstuhl Regional Medical Center (LRMC), [redacted] as to whether LTC Stemmer's clinical privileges whould be reinstated, restricted (limited), suspended, or revocation continued.

c. The Chairman further advised LTC Stemmer that the hearing was, IAW AR 40-68, closed to the public, that he has a right to request the presence of an observer. LTC Stemmer requested that CPT [redacted], Area Defense Counsel, be present on his behalf. This request was approved. LTC Stemmer was informed that the hearing proceedings were being recorded for the sole purpose of assisting the recorder in preparing a summary record of the hearing proceedings, after which the recordings would be destroyed. LTC Stemmer indicated that he understood the process in which the hearing would be conducted, that he understood his right to counsel, and the limitations imposed by AR 40-68 ragarding his counsel's participation in the hearing and the possible actions available to the Chairman if the rules of participation were violated.

d. LTC Stemmer was asked if he had received a copy of the Privacy Act Statement in TAB 0 of the exhibit package. LTC Stemmer indicated he was in posession of this statement and understood the purpose for which the information obtained at this hearing can be used. LTC Stemmer was also verbally informed that the documents presented and generated at the hearing are considered "Quality Assurance Documents", that they are considered confidential in nature and protected from disclosure pursuant to Title 10 United Staes Code Section 1102(b). Unauthorized disclosure of information presented or discussed in these proceedings to third parties is subject to penalties under Title 10, United Staes Code, Section 1102(e). LTC Stemmer indicated his clear understanding of the confidentiality statutes.

e. The Chairman reviewed the index of exhibits as being documents that will be considered by the hearing committee and will be attached to the hearing record summary as evidence (TAB A thru P). LTC Stemmer was asked if he received a copy of Exhibits A thru P as described and he indicated that he had indeed received a copy of these documents.

f. The Chairman called the first witness, [redacted]. [redacted] identified himself as the Chief of the Otolaryngology Service at LRMC, a Board Certified Otolaryngologist and the senior US Military otolaryngologist in Europe. [redacted] noted that he was assigned to the Frankfurt Medical Center as Chief of Otolaryngology Service prior to his reassignment to LRMC as Frankfurt was closing. While at Frankfurt, [redacted] served as Otolaryngology Consultant for 7th

MEDCOM and now at LRMC as the Army Otolaryngology Consultant in Europe.

[redacted] asked [redacted] if he wrote the memorandum to the DCCS dated 10 October 1994 {TAB L}: [redacted] replied that he had after which [redacted] asked if he still felt that LTC Stemmer's practice was as described in this memorandum. [redacted] replied that he felt the same problems existed, in fact perhaps to a greater degree than when he wrote the 10 October 1994 memorandum. [redacted] noted that [redacted] had presented a series of case reviews regarding LTC Stemmer's clinical practice to the Credentials Committee on 13 October 1994, in which it was indicated that LTC Stemmer's clinical practice was substandard. He then asked [redacted] if he still felt the review of the cases {TAB M} indicated problems in LTC Stemmer's clinical practice, to which [redacted] indicated "yes". When asked by [redacted] how serious he felt these cases were, [redacted] indicated that they are serious and that these are just a random sampling of the problems found in cases managed by LTC Stemmer. [redacted] then stated these cases demonstrate a significant deficiency by LTC Stemmer in knowledge base, problem solving and record keeping. He stated that these reviews demonstrated clinical practice which was simply not in step with the practice of otolaryngology today. [redacted] asked [redacted] if, in the Otolaryngology Service reviews, these were the only cases of LTC Stemmer's which showed problems. [redacted] indicated that this was simply a random sampling of problem cases handled by LTC Stemmer that in fact 80 % to 90 % of the cases LTC Stemmer handled have significant problems very similar to those found in the specific cases reviews in TAB M. The specific cases presented are cases that were brought to the attention of [redacted] by other physicians who have referred patients to the LRMC Otolaryngology {ENT} Service for care. [redacted] noted that in overall review of Stemmer's cases, these deficiencies have been found to be the norm rather than the exception. [redacted] noted that part of the documentation presented to the Credentials Committee in October was a review of all the providers in the LRMC ENT Service for clinical pertinence from January to June 19[redacted] {TAB N}: [redacted] asked [redacted] if the relatively few problems noted in [redacted] and [redacted] charts were of the same magnitude as those deficiancies found in Stemmer's charts. [redacted] indicated that the 4 % of charts from [redacted] and the 1% of charts from [redacted] which fell out contained deficiencies of a minor nature as compared to the 13% of charts of Stemmer with deficiencies of mostly a major nature. Stemmer's charting deficiencies included such things as consent forms not indicating the same procedures as those that were performed, physical exams being documented as "normal" for the area in which surgery was performed and in some cases, the absence of a physical examination at all. On some occasions, the operative reports were difficult to interpret even as to what procedure was actually done, and in some cases, the operative report documented procedures being done in ways that are not recognized by the otolaryngology profession.

[redacted] asked [redacted] when he first became aware of potential problems with Stemmer's practice. [redacted] replied that potential deficiencies in Stemmer's practice were brought to his attention in about February 1994. This was while he was assigned in Frankfurt and was also the 7th MEDCOM Otolaryngology Consultant. He indicated he was contacted by another physician who was gravely concerned about deficiencies in Stemmer's practice. [redacted] indicated this was the first time he had heard of any problems with Stemmer's practice. He asked the provider who complained for specific instances which were provided, after which he felt there was enough evidence to warrant further review. He notified the Commander at LRMC at the time, [redacted] requesting that LRMC conduct an internal investigation [redacted] indicated that he was ultimately tasked by 7th MEDCOM to conduct an investigation in his capacity of Otolaryngology Consultant to 7th MEDCOM. [redacted] indicated that his investigation identified significant problems which he reported to the LRMC DCCS and Credentials Committee in his written report. This investigation was conducted in March 1994 and the report was submitted approximately in early April 1994. [redacted] asked [redacted] what the ultimate outcome of the investigation was. [redacted] replied that the Commander ultimately restored full unrestricted privileges to Stemmer. [redacted] then said that when he was reassigned to LRMC in May or early June 1994 as the Otolaryngology Service Chief, he initially reviewed charts of all the ENT physicians to get a feel for the practice habits and capabilities of each provider. [redacted] stated that he, once again, found major deficiencies in the practice patterns of Stemmer. [redacted] noted that prior to [redacted] DCS to LRMC, the QA reviews in the ENT Service were not being conducted as a comprehensive review.

[redacted] requested that [redacted] provide a brief verbal summary of the specific case reviews contained in TAB M of the exhibit file.

[redacted] provided the following case summaries:

Patient [redacted]. Failed to document physical examination; patient was later found to have papilloma on examination by another physician for the same complaint; 6 month delay in diagnosis.

Patient [redacted]. Stemmer's physical examination documented "no palpable masses" on a patient who had a chief complaint of "persistant sore throat. The throat was never examined and no endoscopic exam of the larynx or vocal cords was ever done. The patient, who was somewhat fearful that she might have cancer, returned approximately a week later, quite distraught and crying, saying that her throat was never examined. Apparently Stemmer had discharged her from the clinic with instructions to return again if the sore throat did'nt improve. After doing a complete indirect laryngoscopic exam, the possibility of cancer was ultimately ruled out. The concern here is that a patient with a history of persistant sore throat and an expressed fear of cancer must be considered for a differential diagnosis including that of rule out malignancy. It is a glaring deficiency to do only a palpation exam of the neck and not do at least an indirect examination of the larynx.

Patient [redacted] Referred to Stemmer by Audiology Clinic with concern about voice quality and a differential diagnosis of "rule ou vocal cord disorder". Patient saw Stemmer in February 1994 at whic time he focused his examination and workup on hearing loss Examination failed to include larynx and vocal cords. Stemmer referre patient to speech therapy and allergy clinic. Speech therapy sa patient on 7 March 1994, noted voice problem and documented need for vocal cord examination. Patient returned to Stemmer who once agai failed to document an examination of the larynx, an MRI of the hea was ordered and patient was returned to unit physician for managemen of allergies.

Patient [redacted] This case was also noted by [redacted] in TAB of the exhibit record. This was a 41 year old male with complaint of chronic hoarseness and a long history of being a 2 pack per day smoker. On initial exam in early April or late March, was found by Stemmer to have a vocal cord lesion, was placed on the surgery list in April, but surgery was delayed unti September. The presumptive diagnosis prior to surgery was cancer, eve so, Stemmer placed this patient on a waiting list and the procedure t scope and biopsy was not performed for some 5 months. Fortunately the biopsy was negative, however, had this been a malignancy, th delay of 5 months would have been disasterous. [redacted] noted tha Stemmer had not documented an initial impression in the record on thi patient. [redacted] indicated this represented a judgement deficiency o the part of Stemmer as his explanation for not doing the scope an biopsy sooner was that the patient was not Active Duty which was ou priority. [redacted] indicated that with the serious potential of th presumptive diagnosis, the patient either should have been done her at once or sent out to the economy expeditiously, not delayed for months. At this point, [redacted], Hearing Committee Member, aske [redacted] if he had discussed these deficiencies with Stemmer specifically, the shortcomings in documenting examinations impressions and treatment plans. [redacted] replied that he had not do so in this particular case as Stemmer was on convalescent leave at t time this case was identified, however, other similar cases and t overall pattern was discussed with Stemmer, specifically, tho shortcomings on documenting exams, impressions and treatment plan [redacted] also noted that when he became Chief of the ENT Service, discussed with each provider his expectations for clinical ca standards.

Patient [redacted] This case was also a medical malpractice claim an was thus peer reviewed through the Risk Management Committee (Tab M None of the audiograms on file, beginning with the first in 199 demonstrated normal hearing. The audiograms demonstrated a bilater conductive hearing loss as well as neurosensory component in t right ear. This pattern was demonstrated consistantly throughc multiple audiograms in his record. There was a history of balar problems documented by a pediatrician who then referred the child Stemmer in July 1991 who recorded no mention of the neurosensc

defecit in the record. Subsequently, another otolaryngologist saw the child and placed PE tubes in November 1991. The claim is alleging that the delay in placing PE tubes (July 91 to November 91) is the cause for the child's hearing loss. As would be expected, the conductive hearing loss improved after the PE tubes were placed, however, neuorsensory loss in the right ear did not improve. [redacted] indicated that the concern here is that Stemmer indicated that the hearing loss was as a result of [redacted] surgery, even though there was abundant evidence in the chart that the neurosensory hearing loss was present prior to the surgery. As this case was discussed among the staff, it became evident that Stemmer was unable to interpret an audiogram which is a very basic function for an otolaryngologist. [redacted] stated that Stemmer's workup in this case was deficient, partially due to his apparent lack of urgency in treating the child even with an alleged history of balance problems, which would lead one to consider the possibility of a more serious problem. In this case, it is unlikely that earlier treatment would have altered the outcome, however, [redacted] indicated there are questions raised regarding Stemmer's judgement in that he reached a wrong conclusion and did not manage the case with the degree of urgency one would expect based on the history. [redacted] stated that, once again, this case was typical of many cases managed by Stemmer in which a variety of deficiencies were found in his management of ear disease, sinus disease, and operative activities. There is a consistant absence of documentation of physical examinations appropriate to the complaint or history.

Patient [redacted]. This is an 11 year old child, Downs Syndrome with a history of chronic ear infections and a past history of PE Tube placement two times and a tonsillectomy and adnoidectomy. It was also noted the patient had a perforation of the right tympanic membrane [redacted] stated his initial concern here is that Stemmer made no mention of the fact the child had Downs Syndrome in his history and physical and this point is significant, nor was there mention in the H&P of prior PE Tube placement or the T&A. Additionally, Stemmer noted that he felt the cause of the child's problems was ethmoid sinus disease and indicated his plan to fix the ethmoid sinus disease prior to repairing the TM perforation. There was CT evidence (ordered by Stemmer) that indicated "normal ethmoid sinus" in the chart. The examination documented by Stemmer was contradictory in that he noted "both ear canals normal except as noted below". Elsewhere in the exam he noted a 2mm perforation of the right TM but no mention was made of the left TM. No mention was made of prior audiometric testing. The consent form signed by the parent failed to list any procedure on the ear or nasal pharynx. The intraoperative description in the operative report described "normal ethmoids", completion of a tympanoplasty of the right but with no mention of the technique or landmarks used. The report noted that nasopharyngoscopy identified inflamed adenoids but no corrective action was taken, ie; adnoidectomy. [redacted] indicated that it is inappropriate to identify the adenoid problem and not take any corrective action. Further, he stated he felt Stemmer was

error on his premise for the child's problems, that being based on ethmoid sinusitis when he had CT evidence of normal ethmoids. [redacted] noted his additional concern in this case is that a procedure was performed that was not included in the consent form. The question was asked regarding the history of a previous adenoidectomy and Stemmer's operative report mentioning inflamed adenoids. [redacted] noted that adnoids can grow back.

There were no further questions for [redacted] by the Hearing Committee members. LTC Stemmer was then offered the oportunity to question [redacted], which he proceeded to do.

Stemmer first asked [redacted] if he had ever been in private practice with [redacted] replying that he had not. Stemmer then noted that he and [redacted] had not had much opportunity to talk since [redacted] had arrived at LRMC. [redacted] noted that they had talked on numerous occasions and also noted that Stemmer had surgery and was on convelesant leave for period of time due to his recovering shoulder. Stemmer asked [redacted] for a brief summary of his training to which [redacted] indicated he attended medical school at University of Florida, did a year of surgical internship and one and a half years of general surgical residency at William Beaumont followed by an otolaryngology residency at Brooke AMC, Texas, after which he remained on staff at Brooke followed by an assignment to Frankfurt as staff otolaryngologist for five years, then returned to Brooke as assistant chief to residency training program, after which he returned to Germany and remained to the present time. [redacted] stated, in answer to Stemmer's questions that [redacted] was Chief at Brooke when [redacted] was assigned there and that [redacted] also was there for approximately six months while [redacted] was there. Stemmer asked [redacted] how long JCAHO has existed and how long there has been a JCAHO requiremnet for records reviews which [redacted] responded that he did'nt know for sure but that he has been involved in reviewing medical records for at least the past years. [redacted] noted that as a resident he had not been directly involved in JCAHO surveys. Stemmer then asked [redacted] if the medical record was the only way to assess if a doctor was handling a patient correctly, to which [redacted] responded, "no, but if that is all another physician has available, one must depend on that which is documented in the medical record, particularly the documented history examination and plan for management". Stemmer then asked [redacted] that should be in inpatient charts to which [redacted] replied, "yes, should be in both inpatient and outpatient charts". Stemmer asked each record would be expected to stand on its own to which [redacted] indicated that they should. Stemmer then asked if everything should be repeated in the outpatient record that is in the inpatient record to which [redacted] replied that it should be, at least in summary form. [redacted] further noted that this is particularly important in military society where the population is very mobile and a patient see many different physicians over a relatively short time period. At this point, the Chairman stated that indeed, both inpatient outpatient records should stand alone.

Stemmer then asked [redacted] how he normally does a workup on commo colds to which [redacted] replied that, as a specialist who deals mostl with referred patients, he doesn't see a large number of common colds [redacted] did note that even when seeing a patient with a common cold, h does a full assessment and examination to rule out anything mor serious. Stemmer then asked what sort of an exam he would do in wha he called a "full exam" to which [redacted] stated he would do as a minimu an exam of the throat, oral cavity, ears, nose and neck. Stemmer the asked what he would do if he thought the problem of a patient may b pulmonary in nature, would he refer the patient to a pulmonologist particularly if the patient complained of a cough. [redacted] replied tha this could be any number of things...that if there was nothing foun as an obvious cause, he would do some sort of a direct examination c the larynx. Stemmer then asked [redacted] if a cough could'nt indicate pulmonary problem to which [redacted] replied that, "yes, it could be, can't exclude anything with presentation of a cough, I must eliminat otolaryngology problems before referring on". Stemmer then noted tha there are different types of coughs and [redacted] noted that all types c coughs must be evaluated. Stemmer then stated that some physician believe that different types of coughs indicate differen diseases...if someone believed that theory, would that be a indication of a physician's level of competence? Stemmer then state that he was trying to establish that there are different approaches certain types of coughs may lead one physician to a differer conclusion than it would another physician, to which [redacted] stated tha a physician must still do an examination to ensure the initia impression made by the type of cough was correct. Stemmer then aske if a spasmodic cough would help in making a diagnosis to which [redacted] replied that it would not without the assistance of a complet examination. Stemmer again asked if you could'nt use some of thes obvious things like the type of cough to exclude certian things t which [redacted] again replied that you could'nt without the benefit of a accompanying examination. Stemmer noted here that in view of th workload and the limited time available to see each patient, he fel he had to use things such as the type of cough to limit the time sper on each patient. [redacted] commented that despite the large patien volume and limited time, he did not believe a provider could tak "shortcuts" by not examining certain patients based simply on th "type of cough" they had. Stemmer asked if the presence of a spasmodic cough did not indicate that it may be a lower respirator tract cause to which [redacted] replied that one would still have to do a exam before reaching a conclusion. The Hearing Chairman summarize that several people in the same specialty may have differer approaches to things.

Stemmer then addressed the specific case of patient [redacted] Stemmer said it was clear that he had documented a spasmodic coug [redacted] noted that Stemmer had also documented that patient stated th he "felt like there was a foreign body in his throat" and this shoul have raised enough concern to perform an exam. There was addition

discussion as to whether the patient indicated the sensation was ir the thyroid area and Stemmer noted that in common colds, one does no necessarily examine the larynx. Stemmer said he wanted to make the point that he didn't feel [redacted] when being directly questioned, made it clear that Stemmer's record indicated the patient indicated his sensation of a foreign body in the throat was "in the mid- thyroi area". The Hearing Chairman asked that Stemmer state his points clearly and get to the point he was trying to make. Stemmer made note of the fact that he did not feel that [redacted] has stated all the pertinent information that Stemmer had documented in the chart.

At this point, the Chairman called for a 20 minute recess, from 1050 hours to 1110 hours. Upon reconvening at 1110 hours, Stemme passed out a package of documents to each member of the Hearin Committee and indicated that at this time he would only be referrin to Appendix D as part of his cross-examination of [redacted] {note tha Stemmer's entire package will become part of the hearing record as TA Q}. Stemmer did indicate that he wanted the entire package to becom a permanent part of the hearing record.

Stemmer then referred to his document in Appendix D-II {as labele in Stemmer's package} reference Patient [redacted]. Stemmer stated tha he wanted it made clear to the Hearing Members that [redacted] only note that Stemmer had documented "No palpable masses", when in fact he als documented that there were "no abnormalities found", his point bein that he did address the possibility of abnormalities. Stemmer indicated he had nothing else to present regarding patient [redacted]

Stemmer next referred to patient [redacted] labeled by Stemmer a Appendix D-I. Stemmer stated to [redacted] that he had only referred to or of two consults on [redacted] when making his earlier statements to th Committee. [redacted] refuted that in saying that he had made reference t two consults, one dated 15 March and the other in February. Stemme then asked if the Hearing Committee members had seen these consults t which [redacted] replied that he did'nt know but that he read from bot consults in his earlier testimony. Stemmer said the point here is tha he did document an abnormal ABR {Auditory Brainstem Response}. It is simply put, an EEG of the ear and can be used to rule out an acoustic neuroma pressing on the auditory nerve. Stemmer noted that the firs referral to him was by an audiologist who referred the patient to h with reference to a speech problem. There was considerable discussi regarding the audiology comments regarding diplophonia {the producti of double vocal sounds}. Stemmer made the point that this could ha been a perception by the patient that double sounds were bei produced but in fact were not, to which [redacted] agreed that this cou be possible but is irrelevant. [redacted] noted that the second referr back to Stemmer was in fact by a speech therapist who also referred diplophonia and noted the need for ruling out vocal cord patholog The Chairman restated for clarification that the point here was th there were two referrals to ENT, both expressing concern that the may be some sort of vocal cord problem, and that in fulfilling bo consults, Stemmer did not examine the larynx. Stemmer pointed c

that his record also documented that there had been no allergy managemenmt as of this date.

Stemmer, in cross examination of [redacted] pointed out that reference patient [redacted] it should be noted that Stemmer had "listed" him for surgery, not "scheduled" him. Stemmer also asked [redacted] if he had looked at Stemmer's TDY schedule during the period of the [redacted] clinic visits. [redacted] indicated he had not, but that he did'nt see the significance of the question, in that if a physician is seeing a patient with a potential malignancy, and is then sent TDY, that he has an obligation to have a colleague follow the patient or refer the patient out to another ENT service expeditiously. Stemmer said his point was that [redacted] did not check Stemmer's TDY schedule before making accusations that he had delayed inappropriately a diagnostic procedure.

Stemmer referred to the audiograms on patient [redacted] making his point that the audiograms were not very consistant regarding the level of conductive hearing loss. [redacted] stated that in a 3 to 4 year old child, the audiograms alone are not always reliable due to a child that young not being able to respond appropriately and to focus on doing the audiogram. [redacted] noted that pure tone audiometry is not to be considered alone when testing children; all parts of the audiogram to include pure tone testing, sound field testing and tympanometry with acoustic reflexes must be considered; using these parts, an overall picture can be formulated as to the patient's hearing status.

Stemmer referred to patient [redacted] (Stemmer Appendix D-VI) Stemmer asked [redacted] if he agreed that ethmoiditis can lead to middle ear problems to which [redacted] replied that he did not agree with that premise, that he did not believe that could happen. Stemmer asked [redacted] if he believed that he would have been correct in operating if there were radiological evidence of ethmoiditis to which [redacted] replied "yes". [redacted] noted that an x-ray dated 24 Aug 93 indicated "Ethmoids Clear" and an x-ray dated 15 Nov 93 indicated persistant occlusion of the bilateral ethmoid ostia, although this was not a clear indication of ethmoiditis. [redacted] suggested that Stemmer should have analyzed the x-rays himself prior to doing the surgery. Stemmer asked [redacted] if he felt he could read x-rays better than the radiologist to whch [redacted] replied that he probably could in this area as he works regularly in the otolaryngology field. [redacted] indicated that he always read these type of x-rays himself prior to doing surgery on his patients. Stemmer asked [redacted] if he routinely discussed the x-rays with the radiologist to which [redacted] replied that he usually did not, rather he re-read the x-rays himself.

Stemmer then asked [redacted] when he took over as Chief of the LRMC ENT Service, [redacted] indicated that was on 1 July 1994. Stemmer then noted his surgery on his shoulder took place on 21 July 1994 and asked if they did not have a chance to work together during that 20 day period. [redacted] indicated that he first signed in at LRMC on 1 July after which he had to accomplish all his in-processing. [redacted] noted that Stemmer told him shortly after his arrival, that he was unbable

to operate due to the discomfort in his shoulder and thus they had no oportunity to operate together so that [redacted] could evaluate Stemmer's intraoperative technique. Stemmer denied this, saying that he could certainly have been able to assist [redacted] on minor procedures. At this point Stemmer indicated he had no more questions for [redacted] {Chairman} asked [redacted] if the ENT surgeons worked in teams when doing minor surgery to which [redacted] said they usually worked alone on other than major cases.

Hearing Committee Member [redacted] asked [redacted], reference patient [redacted], "do you not trust the radiologist readings of x-rays?" [redacted] replied that trust was'nt the issue, that "I am the specialist in that area and must see the actual film to make my own interpretation. reading x-rays is an interpretation, I like to read my own x-rays to ensure my own interpretation after which I read the radiologist's report". [redacted] asked to clarify the meaning of "Opacification of sinus", did this mean there was sinusitis? [redacted] clarified by saying that statement does not mean there is sinusitis. [redacted] clarified the difference between "air conduction" and "bone conduction" in audiograms and that interpretation of the differences resulted in the determination of conductive vs sensorineural losses [redacted] noted that the problem with hearing tests on little kids is that you must do several sequences of tests in order to develop a reasonably accurate impression from the tests.

[redacted] Hearing Committee member, asked [redacted] to discuss patient [redacted], one of the cases in Tab M of the exhibit file from the Credentials Committee. This case is discussed by Stemmer in his Appendix D-V. This was a case in which several errors or problems had been identified through peer review and followup treatment. [redacted] indicated there was a complication from this surgery {left Functional Endoscopic Sinus Surgery {FESS} and Caldwell-Luc Procedure on left sinus} done by Stemmer. The complication was a fistula and dehiscence of the operative site, known complication which usually clears spontaneously in 6 to 8 weeks When it does not clear spontaneously, treatment needs to be implemented to close the fistula. This complication was present for over one year before any mention of the fistula was made in the medical record in followup by Stemmer. When the patient was ultimately seen by another otolaryngologist, sinus disease was noted to be present on the right side. A review of the previous CT scan reveals that the disease was always on the right side and that in fact, an earlier CT scan had been mis-read or mis-dictated by the radiologist as having disease on the left side. Another CT was in fact mislabeled, however, if Stemmer had reviewed the CT himself and used the CT to determine landmarks for the FESS, it should have become obvious that the disease was on the right side and that the x-ray had been mislabeled. Stemmer's operative report indicated finding mucosal abnormalities on the left maxillary sinus and the pathology report indicated cartilege, which is difficult to understand as there is no cartilege in the maxillary sinus. If indeed the sinus did have the

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described changes in the mucosa, there would have been tissue specimens to submit and none were submitted. [redacted] went on to describe his concern with the technique documented by Stemmer in his operative report. Post operative CT continued to show the right maxillary sinus disease. [redacted] noted that he was aware of at least one other patient of Stemmer's, a patient [redacted] who also had a post operative complication of fistula and wound dehiscence. In both cases, there was no post operative followup notes in the medical records acknowlwdging the complications. [redacted] noted that endoscopic sinus surgery is a relatively new technique, perhaps in the past 8 to 10 years. With the use of endoscopic sinus surgery, post operative fistulas have become rather rare. [redacted] also expressed concern that Stemmer's operative report did not really describe endoscopic sinus surgery as it is known in the specialty of otolaryngology. [redacted] noted that he ultimately did the endoscopic sinus surgery on the right side for patient [redacted]

At this point, Stemmer was given the opportunity to cross examine [redacted] relative to his testimony on patients [redacted] and [redacted] Stemmer asked [redacted] if he really believed that the left maxillary sinus of [redacted] was not diseased to which [redacted] replied that it indeed was not diseased. Stemmer then noted that there are other ways of determining sinus disease than a CT, such as culture. Stemmer then discussed the x-ray reports on [redacted] (found in Stemmer's Appendix D-V-g. There was agreement that indeed there had been problems within the radiology department regarding the dictation and labeling of two of the CT scans on patient [redacted] [redacted] then pointed out that with two pre-operative CT reports in relatively close time frame, the conflicting findings should have raised suspicion and have prompted the attending physician to discuss with radiologist and examine the films very closely prior to doing surgery. [redacted] stated that if the only x-ray available was the first CT which erroneously alluded to left sinus disease, it would be understandable how the operation could have occurred on the wrong side. However, in this case, Stemmer had ordered a second CT pre-operatively and the report indicated significantly contradictory information, thus the discrepancies clearly should have been resolved prior to the surgery on the left side. Stemmer asked [redacted] if he talked to the radiologist and if he admitted the film was mislabeled to which [redacted] replied that he had done so. Stemmer then asked [redacted] if the radiologist changed the label once it had been determined that the film was mislabeled. [redacted] indicated that was impossible as the labeling was exposed on the film at the time the film was exposed. Stemmer asked if there was an addendum or corrected report issued by radiology, [redacted] indicated that he was unaware of a corrected report being issued. Stemmer asked [redacted] if it were not possible for sinusitis on one side to clear and then later appear on the other side to which [redacted] replied that this is possible but rather unusual, particularly over a short period of time.

The Hearing Committee Chairman called for a lunch recess at 1245

hours. The hearing room was secured during the lunch recess and the hearing was called back to order at 1325 hours. All members were in attendance.

Hearing Committee member [redacted] asked [redacted] to comment on the case identified in Credentials Committee exhibit file in TAB J, paragraph 2c (this is the investigative report by [redacted], OTSG otolaryngology consultant). [redacted] asked [redacted] what a normal workup for a patient with an abnormal ABR would be to which [redacted] replied that it should include an MRI to rule out acoustic neuroma. This patient did indeed have an MRI as ordered by Stemmer which was normal. Stemmer still wanted to air-evac the patient to Walter Reed AMC for workup. The question here was why, when the appropriate diagnostic test had been done to rule out acoustic neuroma, did Stemmer still plan to air-evac the patient to WRAMC. [redacted] noted that Stemmer had presented this case to him as ENT Service Chief for approval of air-evac. [redacted] discussed the case with Stemmer, asking him why he was air-evacing the patient, since acoustic neuroma had been clearly ruled out by MRI. [redacted] said it became clear the Stemmer had no clear understanding of why he was sending the patient to WRAMC. Jones noted that there was no other diagnostic testing available at either WRAMC or LRMC relative to this patient's condition of asymetric hearing loss and abnormal ABR. [redacted] indicated he did not approve the air-evac request and that the patient would be followed here at LRMC. [redacted] indicated his concern here was the demonstrated lack of good judgement on Stemmer's part in wanting to air-evac the patient but not really understanding why. Stemmer began cross examination of [redacted] relative to this case, asking [redacted] if he did'nt think there could be some other kind of tumor in the head other than an acoustic neuroma. [redacted] replied that that possibility was clearly ruled out in that the MRI included the patient's entire head and it was totally negative for any abnormality. Stemmer raised the possibility that there could be a metabolic disorder effecting the patient's hearing to which [redacted] responded that he did'nt think that was likely, and even if it were likely, we had the capability at LRMC to do the metabolic workup. Stemmer indicated he had no further questions for [redacted] in cross examination. [redacted] then asked [redacted] to summarize his overall impression of Stemmer's clinical competence. [redacted] said that, based on his initially being alerted to a concern regarding Stemmer's clinical practice, he had expected to find minor discrepancies in practice and record documentation. After he was appointed as investigating officer by the then 7th MEDCOM, he was horrified at the severity of problems that he found regarding Stemmer's practice. He indicated he did not go out looking for problem cases, they just seemed to appear...virtually every case managed by Stemmer he looked at was loaded with problems. [redacted] closed by saying it "was a degradation of Army Health Care to allow this kind of care to continue". The Hearing Committee members had no further questions for [redacted] advised [redacted] that these proceedings are confidential in nature and disclosure of information discussed at the

hearing to third parties subjects the witness to penalties under federal law, after which he excused the witness at 1336 hours.

g. The Chairman called the second witness, [redacted]er, MC. [redacted] was asked to briefly summarize her professional qualifications. She stated she graduated from medical school, completed internship and residency in family practice, had been on Active Duty in the Air Force since 1985, is board certified in family practice, was an associate professor in the family practice residency program at Carswell AFB, TX, and has been assigned to Ramstein AB Clinic since 1990. She indicated she has served as Chief of Clinical Services at Ramstein since June of 1994.

The Chairman asked [redacted] how, in her position at Ramstein, did she have opportunity to have knowledge of the care rendered in the ENT Service at LRMC. She indicated that her clinic referred many patients to LRMC ENT as they are not staffed with that specialty at Ramstein, she further indicated that most of these referrals are for sinus problems and ear problems, particularly otitis. [redacted] then asked [redacted] what some of her impressions were in regard to the patients that Stemmer had seen in consult from Ramstein providers. She indicated that many times Stemmer would send the patients back to Ramstein to have the Ramstein providers order additional diagnostic tests to include CT Scans and other x-rays. She also noted that patients would be sent back to Ramstein providers with requests to have them write prescriptions for the patient rather than Stemmer writing the prescription himself since he saw the patient. This was a particular inconvenience to the patient as many of these drugs were not carried on the Ramstein formulary, thus the patient would have to return to LRMC in order to get the prescription filled. [redacted] also noted that many of the recommendations for therapy for patients was different than what most physicians were accustomed to seeing. [redacted] also noted that many times Stemmer would send patients back with recommendations for propylaxis therapy when the record clearly indicated failure of prophylactic therapy in the recent past and on several occasions. [redacted] then asked if she had noted differeces between the different LRMC ENT physicians who saw patients in consult to which [redacted] responded that there were definite differences among the ENT physicians. During [redacted] tenure at the LRMC ENT Service, she had presented Continuing Medical Education lectures at Ramstein to help the medical staff there in dealing with patients with ENT problems. [redacted] had emphasized in her lectures that certain types of sinusitis required at least a telephone consult with an otolaryngologist in order to ensure proper management and to determine if the patient needed to be seen by the ENT specialist. She pointed out one case in which a Physician Assistant had called the LRMC ENT Clinic, as [redacted] had advised, regarding a 5 year old, Dr Stemmer refused to complete the phone consult with the PA and indicated he would only talk to the PA's preceptor. The patient was then treated as per the CME lectures from [redacted] Later [redacted] talked to

Stemmer regarding this case, at which time he expressed a desire to know what Ramstein Clinic's protocol was and that if they did'nt have one, maybe they should develop one. [redacted] indicated that their protocol was to do a telephone consult with ENT as had been articulated by [redacted] in her lecture. Stemmer recommended that the Ramstein provider do some sort of procedure using neosynepherine. The Ramstein provider indicated that she was not familiar with this procedure, had not done it previously, and was not comfortable in doing it as it seemed to be a procedure unique to otolaryngologists. Stemmer, when told of this, indicated that perhaps the Commander at Ramstein should get his providers to do this procedure. [redacted] indicated she then discussed the case with her Chief of Pediatrics, who also indicated she had never heard of this procedure and was not comfortable with it either. [redacted] noted another case of an adult referred to Stemmer with a possible peritonsillar abscess, patient was sent back to Ramstein with instructions to have the Family Practitioner write a prescription for a certain antibiotic, one which was not on the Ramstein formulary. He also indicated the patient should do salt water irrigations of the throat with an asepto syringe which should be provided by Ramstein, which also was not available at Ramstein; this is all a reflection of poor judgement regarding patient sensitivity on the part of Stemmer. [redacted] then summarized another case of an 8 year old with a history of strep pharyngitis referred to Stemmer. The patient was returned to the Ranstein clinic by stemmer with a recommendation for the family practitioner to order a CT scan and make another attempt to resolve the problem with an extremely high dosage of Ceclor, particularly in relation to the age and weight of an 8 year old. There was no clear indication documented for the CT scan and there was no mention in the record of the child's hearing history being considered.

[redacted] discussed another case of a 10 month old who was referred to Stemmer for evaluation of a dysfunctional eustacian tube after failed prophylaxis therapy for repeated otitis for which Stemmer prescribed more intensive antihistimine/decongestant therapy. This case came to light when the mother complained at Ramstein that Stemmer had told the mother that he would not prescribe a specific dose of actifed and long term antibiotics in relation to the patient's age and weight but rather the mother should regulate the dose based on how sleepy and inactive the child became. [redacted] indicated the issue here was that it is inappropriate for a physician to ask a mother to regulate the dosage of a medication for a 10 month old based on the degree of side effects demonstrated.

[redacted] asked [redacted] what her impression of Stemmer's clinical competence was based on her interaction with him. [redacted] indicated she finally told her chief that Ramstein providers should no longer allow consults to LRMC ENT Service with Stemmer...they should avoid allowing Stemmer to see patients referred from Ramstein.' [redacted] then asked if [redacted] was aware of any patient complaints against Stemmer at Ramstein to which [redacted] responded that she was aware of at

least two written complaints from patients and several from Ramstein health care providers. [redacted] indicated there was a distinct pattern further demonstrated in the case of a 50 year old male with history of otitis and hearing loss who was seen by Stemmer, sent back to Ramstein with instructions for family practitioner to write prescriptions. Patient later returned to Stemmer on own when his condition didn't improve and was returned to Ramstein with instructions for family practice to request additional specialty consults and diagnostic tests and then to return to see Stemmer after tests and consults were completed. [redacted] indicated this is an inappropriate method of patient management in that the reason a patient is referred to a specialist is for that specialty service to evaluate the patient, get what additional diagnostic tests and other specialty referrals needed, put this all together and implement a plan for therapy. By repeatedly sending the patients back to the referring physician for these additional items, the continuity of care is disrupted as all the results come back to the requesting physician, who has no insight into the logic of Stemmer's asking for these additional items, not to mention the inconvenience to the patient and inefficient use of provider time.

At this point Stemmer was allowed to cross examine [redacted]. Stemmer asked [redacted] what percentage the Ramstein medical staff was of the entire European theater medical staff to which [redacted] replied she did not know. Stemmer then asked if she knew of other physicians in Europe who had complained regarding Stemmer's care.. [redacted] responded that she was unaware of any but that as a practicing physician in a clinic setting she and her medical staff had little interaction with other medical staff in Europe as virtually all their interaction was with the staff at LRMC, their designated referral center. Stemmer then asked [redacted] what sort of specific protocols [redacted] and [redacted] in approximately 1991 or 1992 time frame, had given to Ramstein providers relative to patients seen in their clinic with ENT problems. [redacted] indicated that for routine cases they spoke of using antibiotics for sinusitis along with decongestants and nasal steroids. She indicated that these two ENT providers indicated that the clinic providers at Ramstein needed to know about sinus fluid levels. Stemmer then asked if there had been any advise regarding management of allergy related cases to which [redacted] replied that there were basically two levels of allergy issues. The first being that specific allergies would generally be managed by desensitization and less specific cases by amtihistimines. Stemmer then stressed that in some patients it may be necessary that they take antihistimines on a regular basis. Stemmer ,then asked if [redacted] or [redacted] had specifically told the staff at Ramstein that there were no cases in which a patient would be maintained on antibiotics longer than 10 days for otitis. [redacted] responded that the lectures did'nt get into the detailed management of otitis, but that the lectures were primarily geared toward management of sinusitis. Stemmer then asked how they got their protocol on otitis for Ramstein clinic with [redacted]

stating that this was developed internally between the family practice staff and the pediatric staff. Stemmer asked if [redacted] had placed much emphasis on allergy management in her lectures to which [redacted] indicated that she did not. Stemmer then commented that she "was pretty much of the other school".

Stemmer then directed [redacted] attention to the 10 month old patient with the failed propylaxis which [redacted] discussed and asked [redacted] if she would have simply prescribed a specific amount of antihistimine to the patient, to which [redacted] noted that she calculates a dosage of a medication based on the patient's weight and further emphasized that she does'nt even use tables but actually calculates the dose. Stemmer asked if she did'nt ever adjust the dosage to which [redacted] said that "yes, if there are specific indications to do so...I don't use side effects to determine dosages for a patient". Stemmer then asked if she did'nt feel a patient who is well covered could be drowsy to which [redacted] replied "maybe, I don't use that as my indication for dosage, I may adjust dosage down if side effects are present". Stemmer then asked [redacted] if all these cases she discussed were her patients and [redacted] indicated that, no, only one was her specific patient, that the others were patients of various providers at Ramstein who had discussed the problems with her and that she, in her capacity as SGH at Ramstein, was bringing these cases forward at this hearing and her comments are based on their notes and medical records entries. Stemmer then asked [redacted] if it wasn't true that her main concern was that the patients referred to him from Ramstein were being sent back to the Ramstein clinic to have prescriptions written. She replied that it was not just the fact the patients were being sent back to Ramstein but that normally when you refer a patient to a specialist, the specialist manages the patient for the specific problems for which referred.

Stemmer pointed out that liquid Ceclor has never been on the LRMC formulary and thus any prescription written at LRMC would have to be taken to a different pharmacy to be filled and that LRMC ran out of adult Ceclor and did'nt have any for a long time. Stemmer questioned [redacted] as to her thoughts on why he would have ordered warm salt water irrigation with an asepto syringe on the patient with the peritonsillar abscess. [redacted] indicated that she was not questioning his order for that treatment, only that the syringe should have been supplied by the facility that ordered it and that the patient should have been instructed on the treatment by the physician who ordered it. Stemmer noted that the case just discussed was referred by a [redacted] .he asked [redacted] if any other of the cases she discussed today were referred by [redacted] [redacted] replied that "no, each case she presented was referred from a different provider at Ramstein".

Stemmer then directed her attention to an 8 year old patient she had mentioned which was related to a wrong dosage. The concern was about the way the medication was documented in the chart; the abbreviation being interpreted by the Ramstein physician as 2 capsules while Stemmer indicated his abbreviation was the Latin abbreviation

for "half". [redacted] indicated that the abbreviation Stemmer referred to was new to her but that even if it did mean "a half capsule, it would have been to high a dosage for this child". [redacted] further emphasized that the chart entry by Stemmer clearly looked like "two capsules" as she understood approved abbreviations. She further noted that the prescription was not written by Stemmer but that he had simply made a chart entry and sent the patient back to Ramstein to be seen by the referring provider to write the actual prescription for the medication and the family practitioner had only Stemmer's chart entry as a basis on which to write the prescription.

Stemmer directed the attention of [redacted] and the Committee to his exhibit package, Appendix A-I-d, a letter from [redacted] dated 11 Feb 94 and titled "I've got another Stemmerism for you". Stemmer asked [redacted] if this was a common Ramstein Clinic term; [redacted] replied that it was not, that this was the only instance she had seen that term used. Stemmer asked [redacted] "in reference to the patient which I sent back to you for ther neosynepherine treatment, is'nt it that you did'nt necessarily dissagree with the method but rather that you did'nt understand my method?" [redacted] responded that "No, she did not feel comfortable doing this treatment, I felt we sent the patient to you, a specialist, and you should do the specialist treatment. I did have some discomfort with the method in that a pediatrician with 20 years experience had never heard of this method".

Hearing Committee member [redacted]ham to [redacted]..."You have made it clear that you would not use Stemmer as your consultant, do you feel he should continue to practice medicine?" [redacted] answered "No". Stemmer asked [redacted]."Why?". [redacted] responded..."My concern is in the consultative role". Stemmer challenged [redacted] comment ..."Don't you really mean sinusitis and otitis?" [redacted] responded..."I feel you do not fulfill your role as a consultant...you sent patients back to me to do treatments that I'd sent to you as a specialist...I should not be asked by the specialist I refer to, to do specialty work which is outside my scope of practice". Stemmer indicated he had no more questions for [redacted] The Hearing Committee members were offered the opportunity for any final questions to [redacted] Hearing Committee member, asked [redacted] if she felt Stemmer had ever made any recommendations that could have been harmful to a patient. [redacted] responded that she thought he had, particularly in the case where Stemmer recommended that a mother increase decongestant medications dose to a child until the child started being drowsy...a mother should not be making these determinations...this could be very dangerous to a child. There were no further questions from the Hearing Committee members for [redacted]. [redacted] warned [redacted] that these proceedings are confidential in nature and disclosure of information discussed at the hearing to third parties subjects the witness to penalties under federal law. The witness was then excused at 1432 hours.

The Chairman called for a 10 minute recess. The hearing was called back into session at 1444 hours.

h. The Chairman called [redacted] MC as the next witness. [redacted] was asked to briefly introduce herself. MAJ [redacted] indicated she has been a staff ENT physician at LRMC for approximately the past two years. She is board certified as an otolaryngologist. Prior to being assigned to LRMC, she was Chief of Otolaryngology at Wiesbaden USAF Hospital in Wiesbaden, German.

[redacted] asked [redacted] how she had come to form an opinion regarding Stemmer and his ability to practice. [redacted] answered that initially, after she arrived here and Stemmer was Chief, he appointed her as the "Coordinator of Care for Outpatients" in the ENT Clinic. She indicated her goal was to improve efficiency in the clinic and reduce the large backlog of patients waiting for ENT care. [redacted] indicated she became frustrated that Stemmer would not give the free reign to do the things she needed to do to meet the objectives of improving the clinic fuction, initially the frustration was from an administrative perspective, however, as her role evolved as the clinic coordinator, complaints and questions from patients and other clinics regardimg ENT Clinic were channeled to her to deal with. In this role, [redacted] soon identified a trend of difficulties in having patients seen in referral, particularly relating to Stemmer. As she examined these issues, she began to identifiy clinical questions regarding Stemmer's clinical practice, particularly from Baulholder Clinic and Ramstein Clinic where the referring physicians complained that patients referred to Stemmer were being returned to their clinics without definitive therapy or plans for treatment. [redacted] indicated she would go to Stemmer for assistance in resolving these issues and found it extremely difficult to communicate with him. Finally [redacted] indicated she took her concerns to the 7th MEDCOM Otolaryngology Consultant, [redacted] to seek assistance and advice. Finally, [redacted] was appointed by 7th MEDCOM to conduct an investigation of Stemmer's clinical care. [redacted] indicated she had been TDY for some 7 weeks during the period of the investigation. After her return from TDY, Stemmer was not seeing patients and so [redacted] indicated she saw a large number of Stemmer's patients in followup. [redacted] indicated she noted numerous problems in the management of Stemmer's patients as she was seeing them in followup, such as many of his patients had not been seen expeditiously resulting in unnecessary delays in diagnosis; repeated ordering of unnecessary tests on patients which resulted in undue delays in implementing treatment while awaiting test results and followup appointments, some of these delays were up to 1 to 2 years; many frustrations from the patients were expressed to [redacted] to the point that many patients asked if they could leave their charts with [redacted] for a total review of their ENT care received from Stemmer so that a definitive plan for treatment could be developed. [redacted] noted that she found it difficult to

construct a clear trail of history, diagnosis and treatment due to very limited and inconsistant entries in the medical records. She pointed out the case of a 40 year old male with a growth on the vocal cord which had not been diagnosed. [redacted] found this and operated on the cord, fortunately the growth was benign but could well have been a malignant growth. [redacted] also pointed out that Stemmer exhibited poor cooperation with the other ENT physicians regarding call coverage backup when the on-call physician was in the operating room, generally one of the other physicians would take an emergent call while Stemmer usually refused , indicating that "he was not on call". [redacted] pointed out one particular case in which an emergent child was being transported from Ramstein by ambulance with epiglottitis, a possible airway emergency. The on-call ENT was in the operating room in the midst of a case and the clinic staff asked Stemmer if he would go to the Emergency Room to evaluate this patient until the on-call ENT finished their case in the OR, and Stemmer refused to go to see this patient as he was not on call.

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[redacted] asked [redacted] if her experience of interactions with [redacted] the other staff ENT, were similar to those with Stemmer, [redacted] replied that they were not similar and that [redacted] would take emergent cases when he was available, on-call or not. [redacted] then asked is she had reviewed any of [redacted]'s charts, [redacted] indicated that yes, she had done so. She was then asked if she had the same concerns regarding [redacted] chart entries as she had identified with Stemmer's chart entries, [redacted] responded that no, she did not have similar concerns with [redacted] chart entries. [redacted] Hearing Committee member, asked [redacted] if she were in a civilian community practice, would she have concerns about Stemmer practicing medicine to which [redacted] replied "yes". [redacted] then added that since she has been seeing Stemmer's patients in followup, she believes there are enough problems that she thinks he should not be seeing patients. The Hearing Committee specialty consultant, [redacted] then asked [redacted] what was included in a routine examination for her. [redacted] responded that her routine exam included the ear canals, palpation of the neck, cursury eye exam, nasal exam, naso-pharyngeal exam when indicated, and an oral-pharyngeal exam. [redacted] then asked how much time was allotted for a new ENT appointment. [redacted] id that usually new appointments were 20 minutes. [redacted] asked if that were adequate time to which [redacted] responded that it was not.

[redacted] then asked [redacted] if, based on her review of Stemmer's patient records, could she as an outside consultant, follow the care of a patient being managed by Stemmer. She responded that the assessments and conclusions are frequently the same regardless of the patient's primary complaint...many times the complaints are attributed to allergy problems and the patient is referred to the allergist. She noted that even in cases where an allergy workup had been negative, the ENT followup visit to Stemmer had a documented entry attributing the problem to allergies. [redacted] further stated she had concerns with young kids being maintained on antihistimines for long periods of time by Stemmer and that in some cases this had adverse effects on their school performance, however the symptoms for which being treated did not improve on antihistimines. [redacted] asked if she had ever assisted Stemmer in the operating room to which she indicated she probably had on only one occasion. [redacted] asked [redacted] if she felt Stemmer and [redacted] got along well and if she felt they were in agreement to which she responded that [redacted] got along well with everyone, that [redacted] did'nt have strong feelings regarding the management of the clinic. [redacted] then asked [redacted] if she was aware of any concerns [redacted] might have had about Stemmer's clinical care to which she responded that she was aware of a couple of occasions in which [redacted] had expressed concern about some of Stemmer's patient care; a case in particular was a cancer case referred from oral surgery service in which there was a delay in getting a barium swallow due to a waiting list in radiology and the child with the epiglottitis

from Ramstein when Stemmer refused to cover [redacted] while he was still in the OR.

[redacted] asked [redacted] if she had ever made special arrangements for getting diagnostic tests done on patients she felt were more urgent instead of waiting for their turn to come up on the waiting list. [redacted] responded that she had. [redacted] then asked if, for example, radiology was responsive to such requests to which [redacted] replied that they always had been when she explained the urgency to them, however in the case of the referral case from oral surgery, Stemmer delayed getting the barium swallow because of the routine waiting list and apparently made no attempt to make special arrangements with radiology to expedite the exam.

[redacted], Hearing Committee member, asked [redacted] if antihistimine therapy over longer periods of time were used for acute otitis to which she responded that, no, that that therapy is used more so for chronic otitis. He then asked if in followup of Stemmer's patients, she had seen any who had worsening illnesses, possibly due to his treatment approach. [redacted] responded that, yes, she was aware of one case in which the patient complained of worsening nasal obstruction and sinus pressure who had been followed by Stemmer since late 1992 when Stemmer documented a septal deformity, CT of sinus normal, was on antihistimine therapy for 6 months, had septoplasty, continued symptoms, repeat CT was normal, repeat septoplasty followed by two more CT scans which were both normal, Stemmer's operative report indicated excision of the inferior turbinate. [redacted] said that her exam when she later saw the patient indicated that the middle turbinate had been removed and that there were many adhesions and the inferior turbinate appeared to be untouched even though that was the surgery that was indicated. These findings were different than one would have expected based on Stemmer's operative report. She further indicated that normally the middle turbinate is not removed as removal can cause future problems. [redacted] said that she ultimately had to perform a third septoplasty to correct the patient's problems. [redacted] asked [redacted] where she learned to do endoscopic sinus surgery. She indicated she learned in the last year of her residency plus an additional course in the past year. [redacted] then asked [redacted] where she would have been able to learn the procedure if she hadn't had the opportunity in her residency to which she responded that there are many courses available over the world using cadavers...there are courses available for initially learning as well as refreser courses when one has not practiced the procedure frequently enough to maintain current competence.

[redacted] Hearing Committee member, asked [redacted] to summarize her concerns regarding patient [redacted] which was discussed in earlier testimony. [redacted] presented the following

summary: The mother had brought the patient and 3 volumes of records to [redacted] to review in February 1994. The mother had concerns regarding future plans for managing the child's problems. The child was a Downs Syndrome child who had been maintained on antihistimine therapy by Stemmer for some 5 months which had additional depressive effects on the child and the mother was questioning if this was necessary as the child's symptoms had not improved significantly: the child had been seen in referral by an allergist and allergy had been ruled out as a source for the child's ear problems. [redacted] indicated that on exam she found a dense bed of adenoid tissue which was obstructing the eustacian tubes, and an adnoidectomy and ear tubes were recommended. Due to Active Duty backlog for surgery at LRMC, the child was ultimately taken to a German otolaryngologist who performed an adnoidectomy in July 1994. Subsequently, the child has done quite well and is no longer taking antihistimines, has demonstrated improved hearing and the perforated TM has remained closed. In reviewing Stemmer's record entries, [redacted] indicated it was difficult to follow his findings from visit to visit, particularly what he found on examinations. She indicated this patient was a difficult patient with very small ear canals which made her difficult to examine. [redacted] said she felt that either Stemmer did'nt examine the ears or he failed to document his examinations over approximately a year's worth of outpatient visits. [redacted] noted that in this case, Stemmer had performed one tympanoplasty which did'nt work. The German otolartyngologist at Homberg also did a revision tympanoplasty at the time of the adnoidectomy. The initial operative report by Stemmer identified enlarged adenoids but he did not remove them. [redacted] also stated that there is general agreement among ENT practitioners that if, after two sets of PE Tubes the problems persist, an adnoidectomy would be indicated. [redacted] then asked [redacted] if she would consider endoscopic sinus surgery a major surgery to which she replied that some are more major than others due primarily to the anatomical deviations in various patients; she indicated if she had to choose one category, she would have to consider them major, primarily because if one does'nt have the right training, they could easily hurt the patient. [redacted] then asked [redacted] in reference to patient [redacted] what observations she had regarding the case under review in exhibit file TAB M. She indicated that the operative report did not appropriately describe the current technique for Functional Endoscopic Sinus Surgery (FESS), the documented procedure does not describe the technique normally learned since FESS has become an accepted procedure, the entry documented by Stemmer does not make sense, does not fit the description of FESS; the operative report does not define FESS even though Stemmer termed his procedure as FESS in his report.

At this point Stemmer was offered the opportunity to cross

examine [redacted] which he proceeded to do. Stemmer initially addressed the testimony of [redacted] regarding the clinic management by [redacted] He asked her if she felt she had been thrown into a situation she was not ready for to which [redacted] replied that she didn't feel that was the case, rather, she felt she had a plan to improve the operation of the clinic but was not given the freedom by Stemmer to implement her plans and make changes; she said that Stemmer would indicate he didn't like her ideas but would not put forth alternative methods whereby clinic efficiency could be improved. Stemmer then stated that it sounded to him like she was characterizing the differences in work relationships she had with Stemmer vs those with [redacted]

Stemmer then proceeded to address the two cases [redacted] had testified she felt indicated disagreements between Stemmer and [redacted] Stemmer asked, reference the epiglottitis case, "how did you come to this conclusion?" [redacted] responded indicating that the clinic staff had come to her saying they had called [redacted] in the OR and he had asked that they have Stemmer see this emergent patient, which they did, and said that Stemmer had refused since he was not on call, after which the clinic staff asked her to respond to see this patient which she did. Stemmer then stated that he was not aware the patient may be emergent in nature as the clinic staff had not told him that information. [redacted] said the clinic staff had told her that they had specifically told Stemmer the patient was an epiglottitis patient and that he had refused to see the patient as he was not on call. Stemmer then asked [redacted] if she did'nt recall Stemmer's clinic protocol on taking care of patients as clinic doctors rather than interrupting the on-call doctor in the OR...and continued to ask her who was against that policy? [redacted] responded saying that she recalled it depending on the seriousness of the case. Stemmer again asked her "who was against it?" and she responded "I don't know". Stemmer then said, "I'll tell you it was you and [redacted]. [redacted] responded by saying that no matter who held what position, she felt it was important that an emergent case be seen by whoever was first available. Stemmer then asked [redacted] if she really believed that he would refuse to see an emergent patient. [redacted] said that she could only relate what she was aware of regarding this case of epiglottitis. Stemmer then said that he has only his recollection to go on but that he clearly believes that he only found out after the fact that the patient he was asked to see was emergent and that that fact had not been made clear to him at the time he was asked to see the patient.

Stemmer then asked [redacted] to characterize the clinic situation and their conversation when Stemmer asked her to be the clinic coordinator. [redacted] said that at the time there were many outstanding consults to ENT and that the clinic was not meeting the 3 and 10 day access to care rules; that there appeared to be no good solution in sight; and that the clinic was

basically a "zoo". Stemmer asked her how long she recalled the waiting list to be and [redacted] responded that she believed it was around 350 or so patients. Stemmer then asked her what the waiting list was for ENT surgery to which [redacted] said she believed it was around 150 to 200 for each ENT doctor. He asked her if there was any pressure to see Active Duty patients first to which [redacted] responded that yes, there was pressure to see AD patients first. Stemmer asked "PE tubes did'nt have priority then did they?" [redacted] said "no". Stemmer asked "do you recall when we were first told we could begin to send dependents on the economy for tubes?" [redacted] said "not really". Stemmer noted that it was "long after we had built such a backlog" that we were allowed to refer patients out for such things as PE Tubes. Stemmer then stated that "once we could send patients on economy, the "pressure was greatly relieved, do you agree?". [redacted] responded by saying she guessed so. Stemmer then noted that of the some 200 patients on his personal waiting list, some 50 or 60 were PE tubes. He then asked [redacted] what she would tell patients who needed PE Tubes when she knew she had a long waiting list for surgery. [redacted] responded by saying she would first offer CHAMPUS cost share program which was always available; it depended also on the seriousness of the case, real serious cases were either looked at to fit them into OR schedule as add-ons or have them sent out, either on the economy or to CONUS. She said that the non-serious cases she would leave on the waiting list as long as it did'nt become dangerous to the child; the ultimate decision was up to the parents...we make recommendations...when the patient could'nt go on the economy for some reason, she would make arrangements for our OR in the serious cases that could result in injury to the child. Stemmer then asked her if she would'nt use medications while waiting for surgery to which she responded that she would only if the patient responded to the medication, once it was determined that it was a surgical problem, I'd do what was necessary to get surgery done. Stemmer then asked her if she would use antihistimines to which she replied that no, she would use antibiotics. Stemmer then asked "if pediatricians were using decongestants, you'd disagree?" to which [redacted] responded "yes". Stemmer then stated that there are other schools of thought which believed that decongestant therapy is acceptable.

Stemmer then directed attention to the subject of FESS surgery...reference [redacted] earlier comments on patient [redacted], he asked [redacted] if she did'nt agree that there are different methods of approaching maxillary sinus surgery, perhaps considered safer by a particular doctor or group of doctors. [redacted] responded that possibly so...if it were an accepted technique which I would then assume to be published...accepted approaches are based on the anatomy of the patient. Stemmer then asked if she would "not want an endoscope placed in a safe way

just to have a look?" [redacted] said that "that is not what you described in your operative report". Stemmer then said that he "did'nt write the operative report for residents but wrote it for myself so I know what I meant".

Stemmer then addressed the case regarding the resection of the middle turbinate and said to [redacted] "you said it was'nt indicated". [redacted] "No, I said that is not what the operative report said". Stemmer to [redacted] "What kind of disease would indicate surgery on the middle turbinate?". [redacted]: "Growths on middle turbinate which obstruct the drainage of the sinus...abnormal anatomy of middle turbinate". Stemmer: "I'm not sure you are aware of doing sub-mucous resection of the turbinate". [redacted] "Yes, I am. Four CT scans still showed bone..can't regenerate in that short of time". Stemmer: "There are other possible reasons for the CT scans...to see if bone is regenerating". [redacted] "I don't think you need a CT Scan to find what you could find on a simple physical examination...in the military population where many physicians see a patient, it is more important to document examinations and detailed operative reports". [redacted] noted that it is possible that he was ordering these CT Scans for some other reason but if that were so, it was not documented in the patient's chart.

Stemmer then referenced the patient previously noted regarding [redacted] belief that the barium swallow or bone scan radiology request should have been expedited. Stemmer: "You gave the committee the impression that I did'nt try to see the patient expeditiously". [redacted] "No, the committee asked me for a specific reference and I gave this case as an example.. [redacted] took over this case after the patient indicated he felt he could'nt get expedient care from Stemmer". Stemmer: "How many cases should I have that would result, in your opinion, that I should'nt practice medicine?" [redacted] at this point asked Stemmer to please get to his point.

[redacted] pointed out that the cases in the Credentials Committee exhibit file represented the evidence used by the Credentials Committee in making it's recommendation to the Commander to revoke privileges. [redacted] went on to say that neither the Hearing Committee or Stemmer knew what [redacted] or [redacted] were going to say in testimony, and that Stemmer had been made aware of who the witnesses for the Credentials Committee were going to be long before the hearing date. Stemmer stated that he must be given the opportunity to respond to everything brought up by the witnesses in verbal testimony. [redacted] suggested that perhaps the Committee could disregard everything other than the testimony regarding documentation in the exhibit package. Stemmer stated that this minutia was important to be able to address the issues brought up by the witnesses, particularly the otolaryngologist.

A recess was requested and declared at 1626 hours. The hearing was called back to order at 1640 hours.

LTC Stemmer indicated to the Hearing Committee, that after consultation during the recess, he wishes to dispense with further cross examination of [redacted]. Stemmer made the point that since [redacted] had made a statement that she did'nt feel he should practice medicine any longer, he needs to understand why she has reached that conclusion, and that he wanted to go on record as feeling that he should be able to research the records on any case mentioned by any witness in the hearing, even those in which no documention was presented other than verbal testimony; he further indicated that he was concerned about the time that was being used in this hearing and that he did not want to allienate the Hearing Committee members. [redacted] clarified to LTC Stemmer that time is not an issue and that the Hearing Committee was prepared to stay in session as long as need be in order for Stemmer to feel that he had adequate time to present his case to the extent he desired. [redacted] as Hearing Committee Chairman agreed to this and also agreed that the Committee would dispense with calling [redacted] as a witness for the Committee and that further testimony would be limited to the documents included in the Credentials Committee exhibit file and the exhibits presented to the Committee by Stemmer and accepted as TAB Q of the Hearing record. It was agreed at this point to allow Stemmer to proceed with the presentation of his defense. [redacted] advised [redacted] that the proceedings are confidential in nature and disclosure of information discussed at the hearing to third parties subjects the witness to penalties under federal law after which the witness was excused at 1647 hours.

1. LTC Stemmer took the position of witness to present his case at 1650 hours. [redacted] again assured Stemmer that he could have all the time he needed to present his case. Stemmer formally requested that the document package he provided to each voting member be formally entered as his evidence. This package had previously been entered into the hearing record as TAB Q and was formally acknowledged at this time as TAB Q. Stemmer asked that Hearing Committee members make a correction to the exhibit package that he submitted and which was entered as TAB Q in the hearing record. This change is on page 3, paragraph 10, line 2, Change "Appendix F" to read "Appendix C" which is a comprehensive report of all the medical problems and my request that I be allowed to voluntarily suspend my privileges due to heath problems. Stemmer asked that before he begins his presentation, the Committee members be allowed 20 minutes to read the introductory portion of his documentary exhibits entered into evidence as TAB Q. The Chairman allowed this and 20 minutes were set aside for the Committee to read this document. Stemmer

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further requested that the Hearing Committee consider, in detail, the documentation he has submitted as TAB Q prior to reaching a decision on a recommendation to the Commander. After all members indicated they had read that portion of Tab Q as requested by Stemmer, the hearing proceeded with Stemmer presenting a summary of his documentation.

Stemmer referred the Committee members to his Appendix A of TAB Q, pointing out that this document, along with some supporting evidence, provided substantiation of his being treated in a biased manner at LRMC. Stemmer then referenced his Appendix B of TAB Q, noting that this documentation refers to the time his clinical privileges at LRMC were initially placed in abeyance in April 1994 and subsequently reinstated by [redacted] then Commander of LRMC, which cleared me of any wrongdoing. Stemmer pointed out that the bias against him began at the time he first entered the US Army and attributed this bias to the fact that he was the only otolaryngologist in the Army that was not trained in an Army training program. He also pointed out that his documentation indicates [redacted] ENT Service Chief when he arrived at LRMC, was intimidated by him and had a fear that he would replace her as Service Chief and that this was complicated by [redacted] husband being the Chief of the Department of Surgery at the time. Stemmer commented that the impressions created by his privileges being placed in abeyance two different times and the accompanying investigations all detracted from patient care for his patients; these interruptions resulted in lack of continuity of patient care for his patients, all this was due to the investigations, not due to his incompetence. Stemmer also noted that for example, the alleged case of his failing to followup on the patient with cancer, that the patient had indicated he had German insurance and would get it taken care of in a German facility, this of course after he had informed the patient that he was unable to due the surgery because of his shoulder problem. Stemmer pointed out that, following these disruptions, he applied for transfer to the US Navy.

[redacted] asked Stemmer why he felt [redacted] continued to review his cases after he was assigned to LRMC as ENT Service Chief. Stemmer responded by saying that he felt this continued investigation was due to [redacted] bias against him and the fact that he applied to the US Navy for transfer to the Navy Medical Service. [redacted] also queried Stemmer regarding his writtem comments in paragraph 10 of his introductory memo on his exhibit in TAB Q where he alluded to the "sinister calculated malicious motivation", the question being how do you know the motivation of these people? [redacted] then asked Stemmer if he remembered the discussion that [redacted] {Chief, Department of Surgery} and LTC Stemmer had on several occasions regarding Stemmer's patient care and the concerns related to his care as well as his clinic management style; and that [redacted] had

BY [signature]

issued a letter requiring more detailed, criteria based review of the records and care rendered by all assigned surgeons...Stemmer acknowledged these discussions had occurred. At this point, [redacted] suggested that the committee discussion and questioning get back to the subject of clinical evaluations of the clinical practice of Stemmer, specifically the cases upon which the revocation of his privileges were based and that Stemmer limit his comments to factual information.

Stemmer said that he did'nt feel he had access to the medical records relavent to the cases presented in Tab J and Tab M of the Committee exhibit package. Stemmer asked the committee to ignore some of the previous testimony which alledge that only his methods were inappropriate, bur rather consider only the two cases in which complications were noted. Stemmer then alleged that all but two of the cases presented in the exhibits have never been reviewed through the Department Of Surgery Internal Peer Review process. Hearing Committee member [redacted] asked Stemmer to clarify an earlier statement in which he stated he believed [redacted] felt threatened by Stemmer's credentials and thus was jealous of him. Stemmer confirmed that he had made that statement and believed it to be true. [redacted] then asked Stemmer if he was saying there were no errors in his clinical practice in those case reviews presented in the Credentials Committee documentary exhibits. Stemmer responded, saying that certainly in 35 years of practice he had made errors but that "I believe there are no errors in judgement on my part in these cases".

[redacted] pointed out that, prior to [redacted] letter after Stemmer's first abeyance in April 1994, there were not adequate criteria based surgical case review activities in place within the Department of Surgery. The review system in Surgery is that in order for cases to be discussed at the department level, the specific clinical service must report the case to the department level. [redacted] reinforced the point that not all cases are reported to the department and thus reported through minutes to the Medical Center ECOMS or Risk Management program. Stemmer noted his disagreement, that in fact several of these cases were discussed in the service peer reviews. Stemmer pointed out that he developed a system of chart review for ENT after [redacted] letter which required a better review program within the Surgery department. Stemmer also pointed out that both [redacted] and his past experience was that chart reviews were informal, where we reviewed each others charts and discussed informally any issues we noted. [redacted] pointed out that his policy since being at LRMC has been that case review be conducted based in specific criteria and be formalized, even though this may not always have been done.

[redacted] Hearing Committee member, asked Stemmer, in reference to the two cases in which earlier testimony indicated that he had failed to examine the vocal cord, patient [redacted] and

[redacted], "Did you examine the vocal cords?". Stemmer's response was that "I was satisfied with my decision to refer the patient to pulmonology and that I had instructed the patient to return if pulmonology found nothing". [redacted] then again asked Stemmer for a specific answer, "did you examine the vocal cords?". Stemmer responded by saying that "No, I did'nt feel it was indicated, when [redacted] looked at the cords it was 6 months later and the symptoms were more pronounced, and in fact the path report showed that it was not a papilloma". [redacted] noted that the first thing he was taught in medical school was that you "look at the larynx when you are confronted with a complaint of persistant cough". At this point Stemmer said that he did look at the vocal cords...with a mirror, and identified no positive findings. [redacted] then asked for clarification, first you said you did'nt look at the cords, then you said you did...what is the answer? Stemmer: "What I really meant to say is that there was no need to examine the cords, in my normal practice, yes I do examine vocal cords". [redacted] "As an ENT specialist, do you examine vocal cords in a patient with a chronic cough?" Stemmer: "This patient did not have a chronic cough, he had it only a few weeks". [redacted] "would you not document a vocal cord exam if it is a significant portion of an exam based on the symptoms?" Stemmer: "Maybe, do to the walk-in clinic and the fast pace, I may have taken some steps to save time". [redacted] "Part of your differential diagnosis was laryngospasm...it would seem that a cord exam would be necessary". Stemmer: "Yes, I probably did that...routinely I examine the larynx but I failed to write it down here". A Committee member then asked Stemmer if he believed in the philosophy that "If it was'nt written, it did'nt happen?" Stemmer: "No, I did'nt feel documenting this exam was critical to the case, thus I did'nt document it".

[redacted] then referred Stemmer to one of the cases [redacted] had noted in TAB J, the German patient with the allegation of a delay in referral, the 41 year old patient with a 15 year history of cough, he then asked Stemmer for his response to the allegations regarding this case. Stemmer: "Patient was a German dependent of a military and the criticism was that I did'nt evaluate the patient rapidly enough; it was'nt a matter that I missed anything, it was a matter of timing. "That particular patient came in just a day before I was to leave on TDY and leave. " I told the patient that I would ordinarily do him very expeditiously, I told him I thought it was very serious, I even used the word 'cancer', being German, I even used the word 'Krebs', so that he understood, and he said that being German, he had German insurance and he would go to his German doctor. "I said, fine, make sure you get it taken care of right away. "This patient then came in about the middle of my convalescent leave by [redacted] leave, I was called back from my convalescent leave by [redacted] because of the large backlog. " I saw the patient and asked him

what had happened, did you get this taken care of? "The patient said, no, that he was not able to see his own German doctor as he had planned, I immediately went to [redacted] I did not realize that [redacted] would consider that an infraction of care, otherwise I might not have." Stemmer went on to state that [redacted] did not communicate with him on any of these patients. [redacted] then asked Stemmer if he had written out a referral to the German physician for this patient to which Stemmer said that he did'nt recall. [redacted] then asked Stemmer if he had documented the referral to the German doctor in the medical record to which Stemmer indicated that he certainly did, however the record is'nt available to verify that. [redacted] then asked Stemmer if he had offered an urgent biopsy to this patient and Stemmer indicated that he had done so but the patient chose to go to the German doctor.

[redacted] queried Stemmer about his training in doing endoscopies noting that his techniques are apparently different from the other otolaryngologists here. Stemmer indicated that he was "trained before that period of time, my many years of experience has allowed me to develop my own technique; no, I have not taken specific training in the Kennedy method, the current approach; my technique is unique to me, a modification of modern technique...combined with the older method, I look to the point where I can determine if I need to do a Caldwell-Luc procedure; there is an increased frequency of complications with the Kennedy method". Stemmer was then asked if anyone else was using his technique to which Stemmer responded "Yes, I have been using endoscopy for years, to remove foreign bodies and such". Stemmer was then asked if that type of endoscopy was not somewhat different than that used in sinus surgery to which Stemmer replied "Yes it is but we do use endoscopy". Stemmer was then asked "training for laryngoscopy taken in Frankfurt does not necessarily qualify one to do sinus surgery?" Stemmer responded "I don't think just because you've used endoscopes in one area, you can't use them in another so...I've been examining using endoscopes to examine sinuses long before [redacted] even started describing the technique".

Committee member [redacted] directed Stemmer's attention to [redacted] report in TAB J, paragraph 2. a., patient [redacted] a case that has been discussed earlier. Stemmer said, "yes, thats the patient that i'm supposed to have operated on the wrong side, thats the one I did discuss with [redacted] that I was following what the x-ray had been interpreted for, and at that particular time the patient had other clinical signs of infection; [redacted] did not give you the full picture; he did not even mention that the complaints were bilateral, patient had sinusitis on both sides, I was trying to make it clear that the x-ray report on 4 January shows that both sinuses were involved; now I do not recall going over those x-rays in the kind of detail I normally

do, but if there was an error in labeling, I just would not expect it, [redacted] did not come to me and say, hey, we got this patient here and since you're standing right here, and since I see you every day, whats going on, did you really do the wrong side? and I would have then hopefully been able to go through all the x-rays with him and work out whether I really went by the labeling on the x-ray but I think thats natural that my examination supports his disease is bilateral and finally I mentioned the fact that I did have a positive culture from that sinus". Stemmer also noted that the patient's complaint was of generalized discomfort and not limited to just one side. COL [redacted] "The first x-ray showed the disease on only one side, right?" Stemmer: "I don't know for sure, I think, and its only the third one that mentions both sides". Stemmer further stated that the patient "did not point to a specific place and say, 'pain right here, not at all', he complained of generalized headaches, generalized sinus symptoms".

[redacted] Hearing Committee member and also Chief of Radiology, noted that the x-rays involved here are indeed very confusing. On the first x-ray, the right side is actually labeled as the left, on the second, there was a mistake in dictation, what really appeared on the film was documented in the radiology report as being found on the opposite side. [redacted] did however, point out that in none of the films, either before or after surgery, was there disease demonstrated on both sides, the key thing on the second report was that the dictated report, at different points, indicated "right" in the body of the report and "left" in the "conclusion" statement, the point being that if one had read the entire report, it should have been recognized as being contradictory and have alerted the reader of the need for clarification.

[redacted] asked Stemmer for his response to [redacted] concerns expressed in earlier testimony regarding Stemmer's ability to interpret audiometry testing. Stemmer responded that [redacted] claim that he was unable to interpret basic audiometry is ridiculous considering he had been in practice some 35 years. Stemmer indicated he "could'nt understand why [redacted] had to go to such extremes, when we talked about it, he interrogated me, had a tendancy to want to stand over me, just tossed the chart in front of me, when he interrogated me there was no dialog at all, I mean he was intent on taking my memo that I wrote to the Credentials Committee, it was not thru [redacted] but was intended for the Credentials Committee, I made it clear that as far as that particular patient was concerned, I only had contact with the patient twice and so to be mentioned in a suit which was the only adverse thing that came across to the Credentials Committee; I made it clear in my documents that the care was found to be approrplate by peer review and the Credentials Committee, there was no sub-standard care. "When I went through these audiograms

with [redacted] he was only willing to look at the first one and not the others where a bone conduction was not even shown. "The audiogram of 16 September shows that the hearing was improved after my treatment so naturally, I'm not going to operate on the patient right away like he would like for you to believe I should have. " It wasn't until after [redacted] surgery that increased hearing loss is demonstrated."

[redacted] then asked, in reference to the air evac patient to Walter Reed when the MRI here was negative, "what would have been your reason for transfer to Walter Reed?" Stemmer: "[redacted] claims that the MRI is definitive and there is no reason to further refer the patient. "I asked [redacted] if he did'nt think there are other possible causes of abnormal ABR, the ABR simply indicates if there may be pathology behind the cochlea, we talked about the MRI being negative does not explain the 30 or so possible causes for an abnormal ABR. "We do not have access to an otologist here and I felt because this patient had either a very early acoustic neuroma, there were many symptoms to support this, and the fact that the acoustic neuroma may have been so small it would not have shown up on the MRI, does'nt mean you have a right to ignore the abnormal ABR under these circumstances and thats why I wanted an otologist to evaluate him." [redacted] asked what tests an otologist would have been able to do that could'nt have been done here. Stemmer: "The otologist has a better understanding, the ABR is somewhat like an EEG, not every neurologist is an expert on EEGs, the ABR is very complex and I for one, did'nt feel that I could make all the differential diagnoses that could have come from this abnormal ABR and I don't think there is anyone here that could do this, I did'nt feel the audiologist were expert enough to do this". [redacted] asked Stemmer if either [redacted] talked to him about this case? Stemmer: "Yes, [redacted] did, [redacted] did not: [redacted] was bent on proving to me that you do not send patients that you have done MRIs on which were negative, that the evacuation system is expensive and that the MRI should be considered conclusive; my communication with [redacted] is always so biased that he would'nt hear any discussion I had to offer". [redacted] then asked Stemmer if he went over his differential diagnoses with [redacted] Stemmer: "I told him I thought there were other reasons for positive ABRs and he mentioned that in his report; he says that I was'nt specific, he did'nt let me be specific, he simply cut me off, "he said the MRI is negative and there is no more discussion". Stemmer was then asked if he had ordered additional studies to pursue his differential diagnosis. Stemmer: "This was one more case that was interrupted in my followup, if I had been in a position to followup on this patient, I'd have had a secretary call the patient back and I would have said, look we have a difference of opinion between two doctors, I don't feel that its fair to not pursue a positive ABR,

and you get the choice , whether you want to take it on up higher, but I never had an opportunity to follow it up like I would have liked to, because I was interrupted in almost every one of these cases, right in the process of their care". Stemmer was then asked what his first line would have been in clarification of his differential diagnoses. Stemmer: "I was'nt able to get diffential clarification, thats why I wanted him seen by an otologist that I felt would be able to take over with more knowledge and more understanding because I am not an otologist". [redacted] asked Stemmer why, if he thought there could be other causes of the abnormal ABR such as metabolic, why he did'nt refer him to such specialties which are available at LRMC. Stemmer: "I probably would have been faulted on the same grounds, why did you refer a patient if its not necessary and then I would have pointed out, heres the reason why, but I would not have been happy, not having an abnormal ABR followed up". Stemmer further stated that this was in the time frame of about when he was scheduled to have his surgery and that "since he took over the patient I presumed he was going to follow up on it and at least see the patient again, yet he makes the point that he doesn't even know what happened to the patient, well I would not have left things like that, I would have certainly had the secretary try to followup on the patient". [redacted] asked if [redacted] had written a progress note on this patient. Stemmer: "I don't recall exactly what his note said, but I think its in there and he makes it clear that he did not make a followup appointment, he saw the patient, he examined the patient after I did, in other words it became his patient but he did not make a followup appointment and I was not aware of that, he did'nt make it clear to me what he was going to be doing with that patient, he just made it clear to me that he thought I did'nt know what I was doing".

Stemmer was then asked by [redacted] when he first noticed problems with his vision. Stemmer: "I really don't know, I don't have that documentation with me but it did go through [redacted] and the chain of command, it probably dates back to maybe 6 or 8 months of frequent glasses changes, the last two examinations were , notable by rather sudden changes in my vision after which I saw the opthalmologist, not just the optometrist, that is when he came up with the diagnosis of cataracts. "My problem with the sugar was first recognized when I had my surgery with an abnormal pre-op finding which the anesthesiologist felt was not so bad as to interrupt my surgery but he suggested that I follow it up and so the opthalmologist also noted that one of the things that can effect rapid vision changes is diabetes and so he was thinking about that too." [redacted] "I don't know exactly when this occurred but with you doing fine work in surgery and knowing you might have a visual problem, why didn't you take some action early on". Stemmer: I was beginning to be concerned about my

vision, especially when it was mentioned to me that it had changed very suddenly, and I believe that patient was one, in terms of temporal relationships, was seen right after that and I do have it as one of my cases and I have made it clear here that that was perhaps a factor in [redacted] saying that we were not communicating because that particular case caught me completely off guard and I'm sure I was baffled to the point where indeed this was the first impression that maybe I did miss it and maybe it did effect my clinical judgement, so thats the first time I really came to a conclusion that I really needed to have these things checked, then of course, I brought my diabetes up to [redacted] and [redacted].

[redacted] then queried Stemmer regarding the [redacted] case {discussed earlier also}, the child with Downs Syndrome, who had recurrent ear infections and failure of PE Tubes two times, "during surgery you identified enlarged adenoid tissue, the general concensus sems to be that you should have removed the adenoids, why did'nt you?" Stemmer referred to TAB Q, and his Exhibit D-6, "the patient was difficult to examine due to Downs Syndrome, had negative naso-pharangeal x-rays as reported by her pediatrician, I could not say to the mother to forget about the ears and just do the tonsils as [redacted] would have led you to believe, so she did not have any clinical findings that strictly pointed to the adenoids prior to her surgery, even though I routinely always get permits for all of these things: however, the mother was already very disturbed, and I could understand because here I was talking about sinusitis as the underlying cause that could possibly have been missed, even by the Commander, here she is, a personal friend of the Commander and I'm not about to start talking about doing a totally different procedure than what the Commander referred her to me for and so I did'nt get a specific permit from the mother to do an adenoidectomy without anything specific I could point to, like the x-rays of the sinuses, the mother understood; second, the consultant focused on the term 'hypertrophy of the tonsils' when I said in my op note 'inflamed' so this was almost an acute inflamation of the adenoids I saw when I did the routine exam that I often do at the time of surgery, the patients asleep and I can easily look at the nasal pharynx". [redacted] "So, at the time you did the exam during surgery, you found the adenoids were hypertophyed and inflamed and you felt she would have needed an adenoidectomy?" Stemmer: "Thats correct and I made it clear to the mother afterwards, that this was a new finding of mine, that the adenoids are a problem, I'm even worried that the grafts may not take and that you have to consider an adenoidectomy first". [redacted] "Would there have been an indication of doing an adenoidectomy at that same operation?" Stemmer: "There are a lot of doctors that believe that once you've done a graft, which is what I did, then in the face of inflamation of the adenoids, you

don't want to complicate it and make it less likely that the graft will take and so I did'nt feel I wanted to stir up that inflamation and compromise the graft.

[redacted] declared a short break at 1843 hours. The hearing was called back to order at 1848 hours.

Stemmer again asked that the Hearing Committee read his documentation in TAB Q completely and consider it seriously before reaching a conclusion and then once you've reached a conclusion, read the first four pages one more time and look at the conclusion in the light of what you've read. The hearing discussion then returned to the issue of the the adnoids that was being discussed prior to the break. Stemmer indicated that he felt the inflamation on the adnoids may well subside. Stemmer also indicated that [redacted] in her testimony, did not make clear that Stemmer only saw the patient two times in followup after surgery. Stemmer further indicated his only seeing the patient two times after surgery was due to the mother's belief that problems occurred after surgery, even though the hearing improved, and he felt that was due to the audiologist misleading the mother into thinking further problems were the result of the surgery. [redacted] asked Stemmer about his preoperative diagnosis and if he was thinking about possible adenoid involvement and Stemmer replied that he "was thinking about it and that is why I wanted to look at them". Stemmer: "Preoperatively I though it was right ethmoid problem, in surgery I looked at left ethmoid and did a biopsy which was dictated as normal mucosa; in the OR I felt the need to look at the ethmoids, I focused on the left where there was a positive x-ray report and did a biopsy on both". [redacted] then asked how he examined the right ethmoid. Stemmer: "With the endoscope". [redacted] "what are you looking for?" Stemmer: "Edema, infection, etc". [redacted] "Can you determine the extent of ethmoid disease by looking with an endoscope?" Stemmer: "No, I can tell if there is a need to biopsy". [redacted] "Did you do just a biopsy?" Stemmer: "No, I got up to get a good look...to see if there was a major problem". [redacted] "And you thought the patient had chronic ethmoiditis?" Stemmer: "Yes, since they happened to look reasonably normal in surgery". [redacted] "Even though you believed there was chronic disease, you did no corrective surgery?" Stemmer: "Yes".

At this point, [redacted] as well as the Hearing Committee members were asked if they had any additional questions of LTC Stemmer. There were none and LTC Stemmer was offered the opportunity to make his summary statement to the Committee.

LTC Stemmer again asked the committee to review his documentary evidence, particularly the first four pages and in particular, paragraphs 11 and 12 of those four pages. LTC Stemmer indicated that the AR talks about a seperate committee from the Credentials Committee to do hearings, "and I know you're thinking in terms of you being the Credentials Committee, but

that is not why the AR has you here, the AR has you here as a Hearing Committee, and the Hearing Committee is to report a seperate viewpoint to the Commander giving two views so that he sees both sides, so I'm asking you to look upon what you're doing in that light, and consider the last two paragraphs of my first four pages of TAB Q, and that you consider the importance of counter-balancing your first recommendation in the role of Credentials Committee, try to give the Commander as much as you can of my views that you feel are supported; thats why I ask you to go through the whole thing one more time; and recognize that any doctor, and I don't hold it against [redacted] or any of the other doctors that I dealt with, but any doctor that is already influenced by things that have gone on in the hospital, by things that were said, innuendos, etc, and I think [redacted] can support me on that, and that [redacted] ran to [redacted] even after I was Chief, she was here a few weeks in transit, and said the whole service is going to go to hell, so on and so on, the fact is that she was very, very clearly biased against me, and I gave you reasons why in my documents, and I can understand how that could carry on to [redacted] and how that would be transmitted, if not directly, certainly indirectly by various people, transmitted I believe also to [redacted]c; [redacted]c is even renting the place that [redacted] rented before she left; there are lots and lots of undertones here and for you to come to a conclusion on the cases here that mainly have been directed at my methods I used when I was under tremendous amounts of pressure to try to triage when thats all the time we had, knowing full well that we had to come back and re-check patients, do more detailed examinations; those kinds of things did effect my methods, those are the kinds of things that are being pointed at here; there are really only two complications, not serious complications, well below some complication rates as high as 19% for some sinus surgery, and my cases came through peer review that did involve, on [redacted] part, my entire clinical practice, because he did not limit it to those cases being reviewed, he has addressed cases that go way back years and years that I am now asked to recall details on; the fact of the matter is that that type of thing, really in terms of methods, needs to be looked at in that light; and finally, I do appreciate you taking the time to review my documentation and to hear me". Stemmer indicated that he has no other tesimony to present.

[redacted] asked Stemmer if he had any witnesses he wished to call and present. Stemmer stated he had none, that everything was in his documentation entered as TAB Q. Stemmer: I have several letters in my package, not just from [redacted] but other doctors which substantiate bias from the otolaryngologist, I want to clarify that this is not all my idea, this is the idea of at least 3 or 4 other doctors and that should be taken into account and because [redacted] is so far away, I can't have him here."

LTC Stemmer was again advised that these proceedings are confidential in nature and disclosure of information discussed at the hearing to third parties subjects the witness to penalties

under federal law. [redacted] advised LtC Stemmer that the Hearing Committee will consider the evidence presented today and make findings and recommendations to the Commander LRMC; the findings and recommendations will become part of the hearing record, which will contain a summary record of the proceedings and the documentary evidence. The hearing record along with the findings and recommendations will be forwarded to [redacted] Commander LRMC, after review for legal sufficiency, for his decision; the findings and recommendations of this Hearing Committee are not binding on [redacted]. [redacted] advised LTC Stemmer that a copy of the findings and recommendations will be forwarded to him along with the Commander's decision. LTC Stemmer was then dismissed from the hearing room.

The Hearing Committee went into closed session at 1909 hours to deliberate the evidence and testimony. After some time in deliberation, the Committee decided to adjourn deliberations to allow each member to review LTC Stemmer's written documentary evidence completely and in detail, prior to reaching any conclusions and agreeing on any recommendations. The deliberations wereadjourned and will resume on Tuesday, January 17th at 0700 hours, after all members have had an opportunity to review the contents of TAB Q in detail.

Deliberations in closed session resumed at 0700 hours on 17 January 1995 and were concluded at 0815. Findings, conclusions and recommendations were reached and will be communicated to the Commander LRMC by written document after review for legal sufficiency.

Encl: as

[redacted]
Recorder

[redacted]
COL, MC
Chairman, Hearing Committee

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-DCCS 20 December 1994

MEMORANDUM FOR LTC August Stemmer, MC, [redacted]

SUBJECT: Notification of Credentials Hearing

1. The LRMC Credentials Committee, sitting in the capacity of a Hearing Committee, will be convened, as you requested, to conduct a hearing concerning the revocation of your clinical privileges to practice medicine at Landstuhl Regional Medical Center.

2. Your clinical privileges have been revoked as a result of allegations of inappropriate clinical practice. Documentation regarding these allegations have been provided to you and for which you signed a receipt on 15 November 1994.

3. Your request for a delay of approximately six (6) weeks for your scheduled hearing has been considered and denied. However, a delay of one (1) week has been granted. The committee has re-scheduled your hearing to be held at 0900 hours on 13 January 1995 in the DCCS Conference Room, building 3766. You have the right to be present, to present evidence and call witnesses in your behalf, cross examine witnesses called by the Hearing Committee, to consult legal counsel, and to be advised by legal counsel at the hearing. It will be your responsibility to arrange for the presence of any witnesses you desire. As a military member, you are entitled to consultation with your legal assistance office but cannot be represented by military counsel. Military counsel can be consulted at the Kaiserslautern Law Center, Kleber Kaserne. Civilian counsel retained by you will be at no expense to the government. While such representatives may attend the hearing and advise you during the hearing, these representatives will not be allowed to participate directly in the hearing and/or speak on your behalf at the hearing.

a. Failure to appear at the hearing, absent good cause, constitutes waiver of a hearing and appeal rights.

b. The time and date of the hearing may be changed by the Chair of the Hearing Committee upon written request, if based on good cause, and if such written request is delivered to the Chair of the Credentials Committee within five (5) days after your acknowledgement of receipt of this notification.

4. The Hearing Committee will call the following witnesses:

a. [redacted] MC, Chief, Otolaryngology Service, LRMC

b. [redacted], MC, Staff Otolaryngologist, LRMC

c. [redacted] MC, 86th Medical Group or a clinical representative

d. [redacted] MC, General Pediatric Service, LRMC

5. This hearing will be conducted in accordance with the provisions of AR 40-68, paragraph 4-9.

[redacted]
COL, MC
Chairman

CF: Hearing Committee Members

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-ENT

Date: 29 Dec 94

MEMORANDUM FOR Chair, LRMC Credentials Committee

SUBJECT: Receipt of Notification of Re-scheduled Credentials Hearing

I hereby acknowledge receipt of the subject memorandum, dated 20 December 1994, of re-scheduled credentials hearing.

Date Received: 29 Dec 94

AUGUST STEMMER
LTC, MC
[redacted]

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BY

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LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

21 December 1994

AEMLA-QA

MEMORANDUM FOR The Record

SUBJECT: LTC Stemmer Hearing Re-scheduling Notification

1. Response to the request from LTC Stemmer to delay his hearing was prepared IAW the decision of the Chairman, Credentials Hearing Committee. Attempts made to ensure timely notification of LTC Stemmer of the changed hearing date were made as follows:

a. Checked DCCS Office copy of DA Form 31, Leave Request, leave address was listed as "Holiday Inn, Rome", without phone number or address.

b. Contacted LRMC Personnel Office to see if sign-out copy of leave request had a phone number...none was listed

c. Contacted European Central Reservation Center for Holiday Inn Corporation (0130-5678) where I obtained the phone and FAX numbers for the three Holiday Inn hotels in Rome.

d. Called all three Holiday Inn hotels in Rome, queried if LTC Stemmer was registered or if he had reservations. In all three cases, the clerks indicated they checked their computer system for current registration or pending reservations. None of the hotels indicted they had a current registrant or a pending reservation for LTC Stemmer.

e. Called LTC Stemmer and left message on recorder indicating date and time of re-scheduled hearing (this call was made by [redacted].

f. It should also be noted that [redacted] lled LTC Stemmer at home on tuesday, 20 December 1994, to advise hime of hearing re-scheduling. He did not answer and COL [redacted] left a mesage on recorder that LTC Stemmer should contact either the undersigned or [redacted] ASAP. As of this date, LTC Stemmer has not responded.

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BY [redacted]

QA&I Program Manager

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-DCCS

16 December 1994

MEMORANDUM FOR LTC August Stemmer, MC, [redacted]

SUBJECT: Notification of Credentials Hearing

1. The LRMC Credentials Committee, sitting in the capacity of a Hearing Committee, will be convened, as you requested, to conduct a hearing concerning the revocation of your clinical privileges to practice medicine at Landstuhl Regional Medical Center.

2. Your clinical privileges have been revoked as a result of allegations of inappropriate clinical practice. Documentation regarding these allegations have been provided to you and for which you signed a receipt on 15 November 1994.

3. The committee will hold a hearing at 0900 hours on 6 January 1995 in the DCCS Conference Room, building 3766. You have the right to be present, to present evidence and call witnesses in your behalf, cross examine witnesses called by the Hearing Committee, to consult legal counsel, and to be advised by legal counsel at the hearing. It will be your responsibility to arrange for the presence of any witnesses you desire. As a military member, you are entitled to consultation with your legal assistance office but cannot be represented by military counsel. Military counsel can be consulted at the Kaiserslautern Law Center, Kleber Kaserne. Civilian counsel retained by you will be at no expense to the government. While such representatives may attend the hearing and advise you during the hearing, these representatives will not be allowed to participate directly in the hearing and/or speak on your behalf at the hearing.

a. Failure to appear at the hearing, absent good cause, constitutes waiver of a hearing and appeal rights.

b. The time and date of the hearing may be changed by the Chair of the Hearing Committee upon written request, if based on good cause, and if such written request is delivered to the Chair of the Credentials Committee within five (5) days after your acknowledgement of receipt of this notification.

4. The Hearing Committee will call the following witnesses:

a. [redacted], MC, Chief, Otolaryngology Service, LRMC

b. [redacted], MC, Staff Otolaryngologist, LRMC

c. [redacted] MC, 86th Medical Group

d. [redacted] MC, Chief General Pediatric Service, LRMC

5. This hearing will be conducted in accordance with the provisions of AR 40-68, paragraph 4-9.

[redacted]

COL, MC
Chairman

CF: Hearing Committee Members

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LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-ENT

16 December 1994

MEMORANDUM FOR Chair, LRMC Credentials Committee

SUBJECT: Receipt of Notification of Credentials Hearing

I hereby acknowledge receipt of the subject memorandum, dated 16 December 1994, of a credentials hearing.

August F Stemmer

Date Received: 16 Dec 94

AUGUST STEMMER
LTC, MC
[redacted]

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LANDSTUHL REGIONAL MEDICAL CENTER
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AEHLA 3 November 1994

MEMORANDUM FOR LTC August Stemmer, MC, [redacted]

SUBJECT: Notice of Revocation of Clinical Privileges

1. On 13 October 1994, the LRMC Credentials Committee met to review your clinical privileges in Otolaryngology Surgery and Maxillo-Facial Surgery. The Committee cited numerous allegations of inappropriate clinical practice in it's consideration of the need to take action regarding your clinical privileges. Your privileges were held in abeyance while a medical evaluation was performed on you and the findings were reviewed by the LRMC Ad Hoc Impaired Provider Committee regarding any impairments that may have an effect on your ability to exercise the clinical privileges you hold at LRMC.

2. On 31 October 1994, the LRMC Credentials Committee again met in special session to review the findings and recommendations of the Ad Hoc Impaired Provider Committee and to make recommendations to me regarding the disposition of your clinical privileges at LRMC.

3. I have carefully reviewed the Credentials Committee's recommendations and have decided to revoke all your clinical privileges at LRMC.

4. Under the provisions of AR 40-68, paragraph 4-9e, you have a right to a hearing before a hearing committee. You have ten (10) duty days from the date of this letter to provide written notification to the Chairperson, Credentials Committee, of your desire for a hearing. Failure to request a hearing or failure to appear at the hearing, absent good cause, constitutes a waiver of a hearing and appeal rights. A waiver of a hearing and appeal rights may result in a report to the National Practitioner Data Bank (NPDB), as determined by the US Army Surgeon general.

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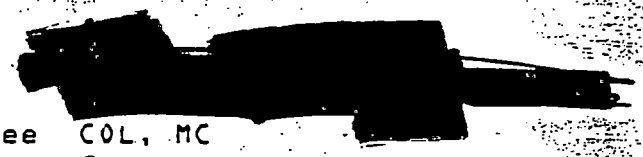
BY

5. In the interest of your personal health status, I have directed the DCCS to ensure that you receive further medical evaluation to include a contrast MRI, posterior neurological evaluation, and a complete neuroopthalmic evaluation at the earliest possible time. Further evaluation does not change, alter or delay the above noted privilege action to include your right to a hearing.



CF: Credentials File
Chair, Credentials Committee COL, MC
Chief, Department of Surgery Commanding

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BY _____

AEMLA

MEMORANDUM FOR DCCS

SUBJECT: Status of Clinical privileges

1. Reference letter AEMLA, dated 2 November 1994, Subject: Status of Clinical privileges.

2. Receipt is acknowledged this date of the above referenced letter. I understand the content of the Commander's decision and am advised that should I decide to request a hearing, I have ten (10) duty days from the date of my acknowledgement in which to provide written notice of a request for a hearing to the Chairperson, Credentials Committee, LRMC, in accordance with the provisions of AR 40-68.

August Stemmer

Date Acknowledged 2 Nov '94

AUGUST STEMMER
LTC, MC
[redacted]

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BY

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LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-QA 31 October 1994

MEMORANDUM FOR Commander, LRMC

SUBJECT: Recommendation on Privileging Action, LTC August Stemmer, MC, [redacted]

1. The LRMC Credentials Committee met in special session at 1200 hours on 31 October 1994 to review and act upon the findings, recommendations and comments of the LRMC Ad Hoc Impaired Provider Sub-Committee (IPC). The IPC was asked by the Credentials Committee on 13 October 1994 to review the findings of various clinical evaluations on LTC Stemmer and to make recommendations regarding his ability to maintain clinical privileges in relation to any physical or mental impairment which he may have incurred. The Credentials Committee on 13 October 1994 reviewed evidence from the Chief of Otolaryngology at LRMC and the Consultant to the Surgeon general of The Army in Otolaryngology which indicated numerous shortcomings in LTC Stemmer's ability to practice his specialty.

2. The LRMC Credentials Committee voted by a simple majority of eight (8) yes and one (1) no, to make the following recommendation to the Commander LRMC:

"That you take action to permanently revoke all clinical privileges held by LTC August Stemmer, MC, [redacted] and to proceed with further clinical evaluation, specifically, contrast MRI, ophthalmologic evaluation, and complete neuropsychiatric evaluation (at Walter Reed AMC)."

[redacted]
COL, MC
Chairman

Encl:

1. Minutes of Special Credentials Committee Meeting, 31 Oct 94, with Enclosures

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CONFIDENTIAL QA DOCUMENT
DISCLOSURE PROHIBITED IAW TITLE 10 U.S.C., SECTION 1102(b)

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-QA 31 October 1994

MEMORANDUM FOR Commander, Landstuhl Regional Medical Center

SUBJECT: Minutes of Special Credentials Committee Meeting, 31 October 1994.

1. IAW AR 40-68, a special meeting of the LRMC Credentials Committee was convened at 1155 hours on 31 October 1994. The purpose of the meeting was to consider the findings and recommendations of the LRMC Ad Hoc Impaired Provider Sub-Committee regarding the clinical privileges of LTC August Stemmer. This committee, at it's meeting on 13 October 1994, tabled making a decision on a recommendation to the Commander regarding the privilege status of LTC Stemmer pending medical evaluation and recommendation from the Impaired Provider Sub-Committee. Consideration of the privilege status of LTC Stemmer's privileges at the 13 October 1994 meeting was as a result of an investigation into his ability to practice appropriately.

2. Attendance was noted and a quorum was present:

a. Standing membership present:

[redacted] COL, MC	Chairman
[redacted] COL, MC	Member
[redacted] COL, MC	Member
[redacted] COL, MC	Member
[redacted] COL, MC	Member
[redacted], COL, MC	Member
[redacted] LTC, MC	Member
[redacted] LTC, MC	Member
[redacted] LTC, MC	Member

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BY [redacted]

b. Others present:

[redacted] COL, MC	Chairman, Impaired Provider Ad Hoc Sub-Committee
[redacted] DAC	Recorder

3. Privileging Actions Considered: This meeting was to consider the findings and recommendations of the LRMC Ad Hoc Impaired Provider Sub-Committee and to make recommendations to the Commander regarding the privilege status of LTC August Stemmer, [redacted]

a. LTC Stemmer's clinical privileges in Otolaryngology-Maxillo Facial Surgery, Category IV, were placed in abeyance by the LRMC Deputy Commander for Clinical Services on 12 October 1994 IAW AR 40-68, paragraph 4-2a,b. The Credentials Committee recommended on 13 October 1994 that LTC Stemmer's clinical privileges be kept in abeyance while several medical evaluations were completed and evaluated by the Ad Hoc Impaired Provider Sub-Committee. On 25 October 1994, the Commander extended the abeyance period for 14 days while the Impaired Provider Committee evaluated LTC Stemmer's case and prepared recommendations for the Credentials Committee.

b. [redacted], Chairperson of the Ad Hoc Impaired Provider Sub-Committee, presented the written report of findings and recommendations along with copies of all medical evaluation consults completed on LTC Stemmer. These consults were from the Neurology Service, Internal Medicine Service, and Psychiatry Service to include Neuropsychological evaluation. [redacted] then presented a verbal summary of the overall Impaired Provider committee findings and recommendations. [redacted] indicated that the full Impaired Provider Sub-Committee membership interviewed LTC Stemmer. He also noted that there was absolutely no evidence of alcohol, drug or any other substance abuse and that there appears to be no clear psychiatric disorder present. He summarized the Sub-Committee recommendation that LTC Stemmer's clinical privileges be placed in suspension until further, more sophisticated neuropsychological evaluations were accomplished at Walter Reed Medical Center. These are tests that are not available at LRMC at this time. It was also noted that the Internal Medicine consult revealed new onset of diabetes.

c. Committee members were offered the opportunity to question [redacted]. Several questions were posed surrounding the possibility of organic disease presence in LTC Stemmer and the possibility for rehabilitation and return to full unrestricted practice, with or without pathologic findings. The following responses were articulated by [redacted]:

(1) There is evidence that LTC Stemmer tends not to be willing to accept criticism and recognize any shortcomings or the fact that he may need to change his practice;

(2) There is reason to believe there is some degree of organic impairment, the degree of which cannot be determined without more detailed testing. Central nervous system impairment of an organic nature cannot be absolutely ruled out at this point in time. In response to specific questioning, [redacted] stated that it is unlikely that, regardless of final clinical diagnoses, there is a treatment that would result in LTC Stemmer ever being able to practice medicine in his specialty;

(3) Noted in response to a question, that the personality testing is in some ways indicitive of a narcissistic personality, however, this cannot be determined definitely due to the lack of an available detailed history from outside sources. This issue none the less surfaces in light of LTC Stemmer's tendancy to always present himself without fault and to project fault for errors onto others. His probable organic limitations are likely effecting his "feedback loop". Even if specific etiology is found, it is not likely to be reversible to the extent that his practice would likely improve. There is little doubt that LTC Stemmer has not kept current in his specialty, however, it is felt that with his personality traits, he would likely refuse to accept entry into a retraining program.

d. [redacted] stated he wanted it known that, for the record, it is alleged that the identifying right and left markers on the sinus x-rays were reversed in one case presented in the special credentials meeting on 13 October 1994. [redacted] further pointed out that this in no way changed the opinion that the standard of care was not met by LTC Stemmer in operating on the wrong side. This issue should be addressed as a seperate issue in peer review in the Radiology Department.

e. [redacted], in closing remarks as Chairperson of the Impaired Provider Committee, indicated that it would be good medical practice to do additional clinical evaluations on LTC Stemmer to include a contrast MRI, Ophthalmological evaluation for cataracts, and sophisticated neuropsychiatric testing currently not available here. These tests would help to rule out the possibility of frontal lobe tumor, microvascular disease, and to confirm presence of a cataract condition and the requirement for corrective surgery. LTC Stemmer indicated he was developing cataracts, however this has not been clinically confirmed. The question was raised on the possibility of further clinical workup identifying some specific organic problem or other significant health care issue, the possibility of treatment and what effect that might have on LTC Stemmer's ability to practice. [redacted] stated that it is unlikely that the results of further studies and subsequent treatment would result in a recommendation that LTC Stemmer would have his privileges restored. Further tests may only confirm an organic disease process which would likely result in medical board action. It was noted that medical board action, if indicated, would take place regardless of LTC Stemmer's privileges status.

f. There being no further questions for [redacted] from the members, he was excused from the meeting. Discussion among the members took place regarding and clarifying the Impaired Provider Committee recommendations, particularly in the need for more medical evaluation of LTC Stemmer.

Options for a recommendation IAW AR 40-68 were explained to the committee members, to include total restoration of privileges, suspesion of privileges not to exceed 60 days, limitation (restriction) of privileges, and revocation of privileges. In deliberations, the committee members also considered the findings of the investigation into LTC Stemmer's practice which were presented at the 13 October 1994 Credentials Meeting as well as the recommendations of the Impaired Provider sub-committee.

g. A motion was made and seconded to "Suspend the clinical privileges of LTC Stemmer not to exceed 60 days, and to order further clinical evaluation, specifically, contrast MRI, ophthalmologic evaluation, and complete neuropsychiatric evaluation (at Walter Reed AMC)". This motion was voted on by secret ballot with the following results:

Yes: 2; No: 7; Motion failed by simple majority.

h. A motion was made and seconded to "Revoke the clinical privileges of LTC Stemmer and to proceed with further clinical evaluation, specifically, contrast MRI, ophthalmologic evaluation, and complete neuropsychiatric evaluation (at Walter Reed AMC)". this motion was voted on by secret ballot with the following results:

Yes: 8; No: 1; Motion carried by simple majority.

4. There being no further business for this special session, the meeting was adjourned at 1320 hours.

[redacted]
Recorder

[redacted]
COL, MC
Chairman

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BY

[redacted]
COL, MC
Commanding

___ Approve 14 Nov 94

___ ~~Disapprove~~

Encl: Report of Impaired Provider
Committee w/associated Consults

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

AEMLA-QA 13 October 1994

MEMORANDUM FOR Commander, Landstuhl Regional Medical Center

SUBJECT: Minutes of Special Credentials Committee Meeting, 13 October 1994.

1. IAW AR 40-68, a special meeting of the LRMC Credentials Committee was convened at 1635 hours on 13 October 1994. The purpose of the meeting was to consider the findings and recommendations of an investigation regarding the clinical privileges of LTC August Stemmer.

2. Attendance was noted and a quorum was present:

a. Standing membership present:

[redacted] COL, MC	Chairman
[redacted] COL, MC	Member
[redacted] COL, MC	Member
[redacted] COL, MC	Member
[redacted] COL, MC	Member
[redacted], LTC, MC	Member
[redacted], LTC, MC	Member
[redacted] LTC, MC	Member

b. Others present:

[redacted], DAC	Recorder
[redacted] COL, MC	Otolaryngology Consultant to the Surgeon General
[redacted], LTC, MC	C, ENT Service

c. Standing members absent:

[redacted] COL, MC	Excused, TDY

3. Privileging Actions Considered: The privilege status of LTC August Stemmer, [redacted] was the subject of consideration at this meeting.

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BY [redacted]

a. LTC Stemmer's clinical privileges in Otolaryngology-Maxillo Facial Surgery, Category IV, were placed in abeyance by the LRMC Deputy Commander for Clinical Services on 12 October 1994 IAW AR 40-68, paragraph 4-9a1. [redacted] MC, Consultant to the Surgeon General in Otolaryngology, was requested to conduct an informal QA investigation into the clinical competence of LTC Stemmer. COL Stambaugh was fortuitously in Germany conducting an annual staff assistance visit and was immediately available to conduct an investigation and report his findings and recommendations to the LRMC Credentials Committee. [redacted] provided a brief background summary of LTC Stemmer's practice since his assignment to LRMC in May 1991.

b. [redacted] LRMC Chief of Otolaryngology Service, and [redacted] Chief of Otolaryngology at Walter Reed Medical center and Consultant to the Surgeon General for Otolaryngology, provided copies of case reviews that have been accomplished regarding LTC Stemmer's clinical practice since his assignment to LRMC along with other documents as follows:

(1) TAB A: Letter from [redacted] to LRMC DCCS dated 10 Oct 94.

(2) TAB B: Summary of medical record review for clinical pertinence, Jan - Jun 1994.

(3) TAB C: Letter to the LRMC Commander, dated 13 October 1994, from [redacted]

(4) TAB D: Copies of LRMC Otolaryngology Service internal peer reviews of 14 cases of LTC Stemmer's patients.

(5) TAB E: Copy of memorandun for record, dated 28 July 1993, from [redacted] DC, Oral & Maxillofacial surgeon.

c. [redacted] briefed the committee membership briefly regarding 8 cases of LTC Stemmer's as summarized in his letter (Tab C). He briefed in depth the case of patient [redacted] Committee members addressed various questions to [redacted] discussion took place, and ultimately [redacted] was asked to state his findings and recommendations. [redacted] indicated that he had reviewed approximately 16 medical records of patients managed by LTC Stemmer along with many of the Otolaryngology Service internal reviews. He also noted that he saw two patients with LTC Stemmer in consultation as well as conducted an in-depth interview with LTC Stemmer regarding clinical knowledge and operative technique. [redacted] stated that he felt there was

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a consistant problem with LTC Stemmer's knowledge and application of current technology in the specialty of otolaryngology. He indicated he had grave concerns regarding LTC Stemmer's ability to practice. In one particular case he indicated that LTC Stemmer demonstrated a basic lack of fundamental knowledge of sinus anatomy and structure, dealing with otolaryngology diagnosis and treatment of sinus disease. LTC Stemmer's surgical procedures seem to be quite outdated and not in keeping with current day teaching. [redacted] stated that LTC Stemmer demonstrates no evidence that he recognizes his deficiencies and has demonstrated no efforts to update his knowledge and skills. [redacted] noted that LTC Stemmer would require, as a minimum, successful completion of one year in a formalized otolaryngology training program before he should hold privileges in otolaryngology-head and neck surgery. [redacted] recommended that at the current time, LTC Stemmer should not have privileges to perform otolaryngology procedures in the operating room and that there is a serious question whether he can manage patients on an outpatient basis.

d. [redacted] after verbally reviewing several cases managed by LTC Stemmer, indicated that he strongly believes that LTC Stemmer is incompetent to continue practicing his privileges in otolaryngology-head & neck surgery. He indicated that he has seen a consistant pattern of inappropriate patient management, poor documentation, surgical errors and poor judgement. [redacted] stated that he has conducted 100% chart review of LTC Stemmer's patients since arriving in July 1994 and that he is hard pressed to find a single chart that documents everything well and that indicates state-of-the-art clinical management. [redacted] indicated that he was of the opinion that LTC Stemmer is currently unfit to continue practice in either inpatient, outpatient, or surgical procedures.

e. Committee members questioned both [redacted] and [redacted] regarding their impressions regarding LTC Stemmer's health and if there may be medical problems that could potentially be impacting on his ability to practice medicine. [redacted] replied that there seems to be a pattern of non-comprehension of dicussions conducted with LTC Stemmer regarding his clinical shortcomings. He indicated that he has repeatedly reviewed a case with him, pointing out certain deficiencies on one day, and within a few days, LTC Stemmer will be confronted with a case of similar circumstances and will make the same errors in judgement and case management as were discussed only a few days earlier. [redacted] stated that at times it seems as if there "is no connection" when conducting discussions with LTC Stemmer. He indicated that this behavior could well be, at least in part, due to some pathologic disorder. [redacted] noted that he is not

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routinely working with LTC Stemmer and therefore does not have the day-to-day contact with him to evaluate his ongoing behavior. [redacted] however did indicate that physical problems could indeed have an impact on a person's ability to make judgements and decisions and indicated that a complete medical and mental evaluation would certainly be in order. [redacted] asked the committee members if there were any more questions for either [redacted] or [redacted] There were none and COL [redacted] excused them from the meeting.

f. [redacted] indicated that LTC Stemmer, when he was being advised of his privileges being placed in abeyance, stated that she recently has been found to have an elevated blood sugar for which he has been seeing an internist. Several minutes of discussion took place among members regarding the possibility of physical and/or mental disorders which could be effecting LTC Stemmer's ability to practice.

4. Committee members were briefed regarding the options available IAW AR 40-68 in making recommendations to the Commander for privileging action. Those options of formal privileging action are as follows:

a. Take no action to restrict {limit} or revoke existing clinical privileges;

b. Suspend existing clinical privileges;

c. Restrict {limit} existing clinical privileges; or

d. Revoke existing clinical privileges.

5. The committee discussed these options and the associated resulting implications. Much discussion centered around the need to ensure that there is not a physicial or mental illness that may be in part or total, a factor in LTC Stemmer's alleged unsatisfactory clinical performance.

6. A motion was formally presented for vote as follows:

"That LTC Stemmer's clinical privileges remain in abeyance; that immediate evaluations {consults} be initiated to have LTC Stemmer evaluated by Internal Medicine Service, Neurology Service and Psychiatry Service; that the results of such specialty consultations be provided to the LRMC Ad Hoc Impaired Provider Sub-Committee NLT 20 October 1994; that the LRMC Impaired Provider Sub-Committee, after appropriate evaluation, make an expeditious recommendation to the LRMC Credentials Committee

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regarding impairment of LTC Stemmer and how such impairment, if found, may effect LTC Stemmer's ability to perform the clinical privileges he has been granted at LRMC."

7. Voting took place by secret ballot, resulting in unanimous approval of the motion with the following specific vote count:

- Eight (8) votes to approve the motion

  Zero (0) votes to disapprove the motion

8. The DCCS will initiate the required specialty consults. There being no further business, the meeting was adjourned at 1840 hours.

[redacted]
Recorder

[redacted]
COL, MC
Chairman

X Approve

___ Disapprove

[redacted]
COL, MC
Commanding

Encl: Tab A thru E, a/s
Tab F, Notification of Abeyance
Tab G, Request for Investigation

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BY [redacted]

10 October 1994

MEMORANDUM THRU: C, DEPT. OF SURGERY

TO: DCCS

SUBJECT: Clinical Privileges of Dr. August Stemmer

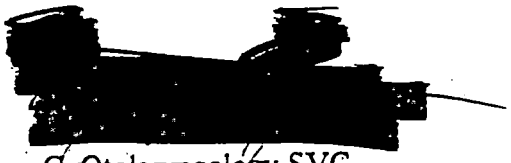
1. Multiple patient records have been reviewed after concerns about the delivery of otolaryngological care by Dr. Stemmer was brought to my attention. All of these cases are new cases which have surfaced within the preceding 30 days. Those cases not discovered by me during routine patient care or routine chart review were presented unsolicited by other health care providers. After careful review of these records it has been determined that the care delivered by Dr. Stemmer is below the acceptable standard.

2. The types of patient problems involved and called to question encompass the entire scope of the specialty and are to numerous to elaborate here. Specific examples are included and can be discussed in further detail upon request.

3. Several cases involve potential risk management issues and will be addressed separately in the ENT Service QA meetings as well. The most significant case involves an operation performed on the wrong side after which the patient developed a complication and several similar complications from that same type procedure have been noted.

4. Serious concerns exist about Dr. Stemmer's ability to take a patient problem and formulate an organized, systematic, logical care plan leading towards a workable diagnosis and treatment. Additionally his documentation continues to be extremely poor often times not including a physical examination as part of the evaluation.

5. It is my recommendation as Chief of the Otolaryngology Service and as the Otolaryngology Consultant to Europe that Dr. Stemmer's clinical privileges be restricted until this matter can be fully evaluated.



C, Otolaryngology SVC
Landstuhl Regional Medical Center

Clinical Pertinence Reviews from

Otolaryngology SVC covering

the period Jan 94 — June 94.

DR [redacted]
DR [redacted] → all included in
DR Stemmer reviewed.

[redacted] 96% Compliance
[redacted] 99% Compliance
Stemmer 87% Compliance.

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all out patient charts (100%) were initially reviewed by me for the first 30 days. Any charts falling out of the accepted standards were looked at.

Most of the cases included in this packet were reviewed by other practitioners. A few were found coincidentally after patient exams or during chart review

[redacted]

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BY _____

13 October, 1994

MEMORANDUM FOR COMMANDER, LANDSTUHL ARMY REGIONAL MEDICAL CENTER

THRU: Chairman, Credentials Committee, Landstuhl Army Reg Med Ctr

Subject: Clinical Performance of LTC August Stemmer

1. As the Consultant to the Surgeon General in Otolaryngology-Head and Neck Surgery visiting in Germany, I have been asked to render and opinion and recommend action on the clinical performance status of LTC A. Stemmer. Several cases managed by Dr. Stemmer have been reviewed. I have first-hand knowledge of two patients seen by both Dr. Stemmer and myself on Tuesday, 11 October. I have had the opportunity to discuss sinus surgery with Dr. Stemmer. I have met with the Chief of Otolaryngology, LARMC, [redacted] who presented several cases to me.

2. There are many concerns that come to my mind reference Dr. Stemmer's practice capabilities. It is difficulat to state whether Dr. Stemmer is just behind times (i.e. has not kept up with developments) or refuses to acknowledge his dificiencies. In either case it appears at least in the cases reviewed by me, that Dr. Stemmer's performance is substandard in some and possibly unacceptable in others. The following eight cases are illustrative of his performance:

a. [redacted] sought help for sinus congestion. This patient underwent a Caldwell Luc operation on the left side by Dr. Stemmer. According to the records and the x-ray films (CT's) this is the wrong side. In addition, the patient developed complications from this procedure i.e. oro-antral fistula. Dr. Stemmer demonstrates no knowledge that he has performed an operation on the wrong side, but instead chose to believe that after the operation the patient develped symptoms on the contralateral side. He never demonstrated in the charts that the symptoms from the patient was secondary to the fistula. There is some contribution on this problem from the radiology department, but the surgeon must look at the films and be responsible for operating on the correct side.

b. [redacted] (another sinus case) sought help for nasal blockage for which Dr. Stemmer performed Functional Endoscopic Sinus Surgery and Caldwell Luc procedure on the left side. Again an oro-antral fistula developed which the reviewer could not detect that Dr. Stemmer was aware of this possibility despite repeated mention of problems in this area by the patient. Additionally, the CT scan preoperatively indicated that all sinuses were opacified on both sides, but despite having called "pansinusitis" on this patient, Dr. Stemmer only does a look at the Ethmoid sinus and does a Caldwell luc procedure on the maxillary sinus on one side. His description of FESS does not resemble anything I am aware as FESS in the literature. Dr. Stemmer has not even taken a course in endoscopic sinus surgery (by his admission). This patient also has devitalized teeth in the area where the caldwell luc approach was

made indicating that perhaps the operation was performed too low and medial.

c. Dr. Stemmer presented a patient to [redacted] for Air Evac clearance. This patient was found to have an abnormal ABR examination (exam done to work up asymmetric hearing loss). Dr. Stemmer ordered an MRI to further investigate. On discussion, it was clear to [redacted] that Dr. Stemmer had no idea why he was transferring this patient to Walter Reed other than the fact that he had an asymmetric hearing loss and an abnormal ABR. He did not understand that the MRI he had ordered would answer the question whether the patient had a Acoustic Neuroma. He did not understand that at this time there is no other difinitive test to work up this type of patient. No air evac was necessary since the MRI subsequently was normal which Dr. Stemmer knew when he sought the transfer.

d. Dr. Stemmer asked me to see a patient on Tuesday who had a stapes operation at Walter Reed some one month ago. He asked me to reassure the patient that the hearing loss on the same ear since the surgery was alright and not to worry. After reviewing the data and speaking with the patient, it was clear to me that Dr. Stemmer had no idea why this patient had the severe sensorineural hearing loss on the operated ear. He had not considered the possibilities and had not discussed them with the patient. He wanted me just reassure the patient that all was alright. He missed the point because of his lack of knowledge.

e. 11 y.o. w. f. for TM perforation referred to Dr. Stemmer by [redacted] There is no mention of the audiogram in the work up for admission. There is no mention of the previous sets of PE tubes on this patient. There is no mention that the child is a Down's Syndrome patient. All of these are significant to the case and must be mentioned. Without any documentation, Dr. Stemmer concludes that the child's ear problem is secondary to ethmoiditis, despite the CT showing no ethmoid disease (also fails to note that there is mucosal thickening in the left maxillary sinus). Pt is scheduled for Tympanuplasty on the right and ethmoid surgery and adenoidectomy. At operation, he does the T-plasty (the op report cannot be interpreted by me in reconstructing what was done) and looks at the right ethmoid area and declared it normal. However, opens into the left ethmoids and takes a biopsy of what he dictates ar normal appearing mucosa. He looks into the nasoph and sees hypertrophied tissue, but elects not to do anything in order to not irritate the eutachian openings. There is much faulty logic displayed in this case. Even if I accept the premise that the ethmoid infections affect the eustachian tube function, with normal CT scans, I could not justify operating on them. Additionally, after finding that the ipsilateral ethmoids is normal, there is no logic to operating on the left, the contralateral side. Almost everyone is in agreement that adenoids have a role in the health of the eustachian tube and adenoidectomy should have been done. This case was totally mismanaged.

f. 45 y.o. AD physician referred for evaluatiion of hoarseness and coughing in 1/94. No mention of laryngeal examination being done. Pt is referred to Pulmonary, Cardiology, and Radiology for CT of sinuses, chest, and neck. Pt referred back to ENT in 7/94 for same continued symptoms and saw another physicain who performed a laryngeal exam and found a papilloma on the TVC. This is unacceptable. There is no excuse for not performing a laryngeal on this patient.

g. 30 y.o. referred by Audiology for diplophonia. There is no laryngeal exam documented and the diagnosis of diplophonia is dismissed and allergic rhinitis tendered. Again the patient is referred, but this time from Speech Path for evaluation of diplophonia. Dr. Stemmer, this time states that patient has Diplacousis and that the patient misinterpreted voice sounds. Again no laryngeal examination is done. This is also unexcusable.

h. 41 y.o. male with 15 yr history of smoking referred for evaluation of hoarseness. The nasopharyngoscopic examination shows a lesion in the anterior 1/3 of the cords with questionable extension to the subglottic area. Pt is placed on the waiting list for direct laryngoscopy and biopsy. Dr. Stemmer appropriately decides to scope the patient and biopsy. It was not until 5 months has passed that the patient was finally brought in for this procedure. This could have been a disaster if it turned out to be cancer. This setting presumes the presence of cancer until proven otherwise and time should not be wasted. Dr. Stemmer could not differentiate administrative priorities of AD vs retired patients and clinical importance of these types of lesions.

3. These cases represent a broad spectrum of the specialty of Otolaryngology-Head and Neck Surgery. In all these areas there appears to be flaws in Dr. Stemmer's ability to appropriately manage patients. There appears to be alck of fund of knowledge and in cases where knowledge is demonstrated, his diagnostic acumen is faulty (at best "not in the mainstream of American medicine.) There is also irresponsibility in performing procedures without adequate and necessary training i.e. endoscopic sinus surgery. There is evidence to show that too much reliance is placed upon the "CT scan" and moreover, reliance on teh interpretation by radiology rather than personally gathering information in conjunction with the interpretation.

4. Dr. Stemmer, probably secondary to his lack of clonical abilities, appears to "smooth over" and "delay" making decisions on patients. The best example is the one that I was asked by him to "reassure" the patient that his hearing loss after an ear operation at Walter Reed is "nothing to worry about." I feel Dr. Stemmer did not appreciate at all, the gravity of the situation and did not appreciate what the expected complications of stapes surgery are.

5. My findings on review of Dr. Stemmer's clinical performance, as amplified in the examples above, is that he is substandard as an Otolaryngologist.

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6. My recommendation is that Dr. Stemmer not be priviledged to perform Otolaryngic procedures in the operating room. There is question whether he can manage patient on an outpatient basis as well. At the least, Dr. Stemmer will require an additional year of formalized training in Otolaryngology-Head and Neck Surgery before being priviledged to practice the specialty.

[redacted]
COL, Medical Corps
Consultant to the Surgeon
General in Otolaryngology

[redacted]

This patient was referred by the Audiologist for a decreased hearing complaint but also because of a concern about **diplophonia** which refers to a quality of the voice where it sounds as though two pitches are heard at the same time. She was seen by Dr Stemmer and he concentrated on the hearing loss and examined the ears but did not examine the larynx. His impression was that the patient had allergic rhinitis with probable secondary left SOM despite normal tympanogram. The Audiologist was concerned about a sensorineural hearing loss rather than a conductive loss which requires an entirely different work-up. There was nothing to suggest a middle ear problem such as fluid. The requested voice evaluation and examination of the vocal cords was avoided.

Dr Stemmer did refer the patient to the Speech Therapist who examined the patient and noted an abnormal ABR along with the previously abnormal audiogram. She also confirmed a diplophonic voice and emphasized the need for an examination of the larynx!! She referred the patient back to Dr Stemmer for this examination.

When the patient was seen again by Dr Stemmer he was upset with the fact that her presumed allergies had not been managed by the referring unit physician. He also now ordered an MRI but based it on " the original suspicion of **diplacousis**" which he thought might have been misinterpreted by the patient. These two entities are totally different and the original consult as well as the consult by the speech therapist is quite clear as to the reason for the referral(**diplophonia**). Once again the vocal cords were not examined!!!!

This case demonstrates the inability of Dr Stemmer to perform what was requested and clinically indicated (ie. a physical examination) despite several requests to do so. This patient as best as I can determine has still not had an examination of her larynx. This is a **major deviation** from the expected standard as all that was requested was a simple physical examination of the patients' vocal cords which was clinically indicated.

[redacted]
C, Otolaryngology SVC
LRMC

10 Oct 94

TAB D

[redacted]

This is a case of a 50yo female with a complaint of a persistent sore throat referred for an examination by an otolaryngologist. The patient was scheduled to see Dr Stemmer which occurred on 20 Sep 94 and a copy of the consult is included. As can be seen by the consult the physical exam is described by Dr Stemmer as **revealing no palpable masses.** There is nothing further mentioned about physical findings.

The patient herself returned to the clinic about a week later very upset requesting an appointment with a different physician because she was concerned that her throat was not examined. She was given an appointment to see me and is currently awaiting that appointment.

The concern in this case stems from the fact that in a patient with complaints of a persistent sore throat particularly in an older patient, a complete head and neck examination is essential to rule out malignancy. There is no way to justify not performing a complete physical examination. This is a major deviation from the expected standard of care.

[redacted]
C, Otolaryngology SVC
LRMC
10 Oct 94

[redacted]

45yo AD physician referred for complaints of **hoarseness** and coughing since Dec 93 The patient was seen by Dr Stemmer in Jan 94 and pointed to his throat and stated he felt like there was a foreign body in his throat. On the physical examination performed by Dr Stemmer, **no mention is made of an examination of the larynx** !! The diagnosis listed was paroxysmal cough of unknown etiology- pulmonary FB vs. bronchitis etc. consider allergy etc. with secondary laryngospasm!!! The patient was referred to the Pulmonary Medicine SVC. Cardiology (a coughing episode resulted in a syncopal episode), and a CT of the sinuses, neck and chest were ordered. The last listed plan was to consider a flexible examination presumably of the larynx if pulmonary medicine did not plan an investigation.

The patient was referred back to the ENT clinic in July 94 where he saw [redacted] He was examined appropriately and noted to have a pedunculated, papillomatous lesion of his left TVC. A biopsy was scheduled and this lesion was removed on 28 Jul 94. Fortunately the lesion was benign only revealing mild atypia.

The potential for disaster in this case is overwhelming. The fact that a fully trained staff otolaryngologist saw a patient with this complaint and actually pointed to the site of the lesion and still was not examined is medical malpractice!! There is absolutely no excuse for this nor is there any way to justify this. This is a **major** deviation from the standard of care.

[redacted]
C,Otolaryngology SVC
LRMC
16 Oct 94

[redacted]

This is the case of an active duty pilot who underwent sinus surgery in March 1993 performed by Dr. Stemmer. The outpatient record is unavailable but copies of the inpatient documents are enclosed. According to the H&P in the chart his sinus disease dates back to 1989 and has progressed to the present state in which he has complete loss of olfactory function. He reportedly has had a polypectomy in May 1992 which is described as only partially successful. The patient also has allergies being treated.

There is no mention made of CT findings in the chart and the physical exam reveals on the one hand **normal nasal mucosa and septum** but at the same time **bilateral obstructive nasal polyps with a deviated nasal septum.** These descriptions which are contradictory are both included in the physical exam. In the physical exam section a mention is made of bilateral maxillary sinus opacification but nothing further is noted nor is it stated that this was a CT scan.

The impression listed was chronic bilateral pansinusitis with polyposis. Pansinusitis describes diffuse sinus disease involving all of the paranasal sinuses which if indeed present should be documented by CT scan and should be so stated.

The operation report describes the procedure as being "Functional Endoscopic Sinus Surgery, Right Maxillary Sinus", "Functional Endoscopic Sinus Surgery, Left Maxillary Sinus", "Bilateral Nasal Polypectomy", and "Left Caldwell-Luc Nasal Antral Window". Dr Stemmer's description of FESS does not follow any recognizable pattern and no anatomic landmarks are described and is certainly not standard technique. It is impossible based upon the description of the procedure to determine where in the nasal cavity the procedure actually took place.

Postoperatively the patient apparently did well but a note found in the inpatient record on 17 March reveals a wound dehiscence in the mid-portion of the buccal incision. There were no further references to this finding in the record. The patient was then discharged.

The follow-up visits indicate the patient was doing well but do not mention the area of wound dehiscence. This patient was seen postoperatively from Mar 93 to Jun 94 and his condition was described as improved but no reference was made about the incision. Sometime in July 94 the patient was seen in Wurzburg by the Otolaryngologist and an oral antral fistula was noted in the prior Caldwell-Luc site. According to [redacted] the patient states that he mentioned this problem during each visit with Dr Stemmer but that no plan was made to repair the area. Dr Stemmer's notes consistently avoid mentioning the incision[redacted] went on to say that this patient also has exposed tooth roots and a question of non-viability of several teeth requiring root canals to attempt to save these teeth. According to her findings the incision in the mucosa and the entry into the sinus was described as too medial and too inferior which would explain the complications.

This fistula is a postoperative complication as are the injuries to the teeth. There is a significant delay in the diagnosis and apparent willful avoidance of its' documentation in the record. The injury to the teeth is a recognized potential complication which should rarely occur and the

fistula rate should occur in less than 1% of cases. It is easily diagnosed by simply examining the incision site after surgery and the patients usually have symptoms as did this patient.

Based upon the postoperative CT scan done 3 months later, the patient did not derive much benefit from his original procedure done by Dr Stemmer and will require further sinus surgery in addition to repair of the postoperative fistula and root canals to attempt to save teeth.

[redacted]
C, Otolaryngology SVC
LRMC
10 Oct 94

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BY

[redacted]

29 Sep 92
Pt initially seen for complaints of sinus congestion by Dr Stemmer in Sept 92
-Imp: chronic allergic and structural sinusitis r/o migraine
-Plan: CT, decongestant trial then reeval

CT scan exam dated 26 Oct 92 handwritten report = loculated fluid at the base of the left maxillary sinus

5 Nov 92
Pt seen again by Dr Stemmer and he refers to CT report revealing left maxillary disease. He states that the septum and the osteomeatal complex do not look bad despite describing a deviated obstructing nasal septum on his clinical exam.
-Imp: HA secondary to chronic sinusitis r/o migraine
-Plan: continue decongestants- 6-8 wks then re xray
trial of ergotamine
return after above- 3 wks on ceclor 500mg q8h or Cipro 500mg q12h

7 Jan 93
Next clinic visit describes prostate symptoms from decongestants and continued HA's with no relief from ergotamine.
-Imp: none listed
-Plan: trial off decongestants
allergy referral
listed for left Caldwell-Luc and possible septoplasty

15 Jan 93
Pt returned for visit c/o more drainage after using saline also reporting jaw clicking according to spouse. Patient noted to have come up on surgery list. Allergy consult reveals no symptoms to suggest allergies even though patient was skin test positive to grasses and no allergy treatment was recommended.

19 Mar 93
Patient underwent "functional endoscopic sinus surgery of the left maxillary sinus", "left Caldwell-Luc nasal antral window", and a "septoplasty". In the operative note Dr Stemmer describes his endoscopic technique which is not the classic description of this procedure and he describes finding the sinus mucosa to show heavy congestion and polypoid changes throughout. For that reason he proceeds with the Caldwell-Luc procedure. The septoplasty was then performed and the procedure was terminated. The pathology report received in the lab describes specimen A: "Antrum": two flat cartilaginous tissue fragments.(The maxillary sinus does not contain cartilage) and specimen B: septal bone and cartilage. If indeed the patient had the above described changes in the sinus mucosa, there should have been tissue to submit. Additionally there is no cartilage in the maxillary sinus so this specimen was labeled in error.

Prior to this procedure no follow-up CT was ordered despite the plan to do so. In this case if the osteomeatocomplex was normal as was described by Dr Stemmer, by merely treating with antibiotics this finding may have been reversed. This could then have avoided the need for sinus surgery all together. This could have represented an acutely inflamed sinus which simply had not been treated.

24 Mar 93
Pt seen after operation with improved breathing and reportedly to be healing well. He was instructed to return in one week.

5 Apr 93
Pt again noted to be healing well now back to work but on exam residual edema is noted on the left but the buccal incision is described as healing well. The plan was to be followed in 6-8 weeks and repeat the CT scan and the mirror exam.

17 May 93
Pt seen and c/o soreness in buccal region and HA now on **right** side. A reference is made to a corrected CT scan report dated 7 May 93 which describes " mucosal thickening and _____ material on the floor of the **left** (corrected to **right**) maxillary sinus just below the level where the Caldwell-Luc procedure was performed. The Caldwell-Luc procedure was actually performed on the **left**. No mention is made of examination of the buccal incision site despite c/o soreness in the area.

For some reason Dr Stemmer elected to recommend desensitization despite the allergist's recommendation to the contrary and he also ordered decongestants again and antibiotics. At this point something should have suggested that there was perhaps a mistake as to the operated side or at least some comment should have been made regarding the confusion on the xray reports. Dr Stemmer also schedules the patient for a right sided Caldwell-Luc procedure after an endoscopic sinus procedure.

Patient seen by allergist again and apparently is treated for allergies.

5 Apr 94
When last seen by Dr Stemmer in May 93 the patient had soreness in the incision but it was not examined. He had an abnormal CT scan on the opposite side of the procedure, he was continuing to have HA and he was placed on antibiotics to treat some sort of presumed infection **but** he was not seen in the ENT clinic for almost one year. On his return he was described as doing better with occasional HA. Again mentioned is a "small whealed area in the left buccal sulcus". The remainder of the clinic note from this date is difficult to read. **The examination again does not make any mention of the buccal incision site.** The impression listed is of "?**right-sided** residual chronic sinusitis!!!! Apparently a follow-up CT was ordered and the patient was to return after the scan.

24 May 94
Somehow the patient was sent back to see [redacted] and she noted exposed alveolar bone in the old left Caldwell-Luc site. She refers to the CT scan and notes the findings of **right** maxillary sinus disease. She refers the patient back to Dr Stemmer for closure of the mucosal defect in the **left** canine fossa and also for treatment of his **right-sided** maxillary sinus disease.

14 July 94
Patient saw Dr Stemmer who notes CT findings now "contralateral" to the surgical side which he describes as now being clear and asymptomatic. If the original CT scan is reviewed it clearly reveals the disease to be on the **right side** from the beginning. The scan is clearly labeled and by looking at the xray it is clear that the radiologist who initially read the scan mislabeled the diseased side in his report.

It is during this visit that the first mention is made by Dr Stemmer that there has been a wound dehiscence of his buccal incision. (Operation Mar 93, now July 94!!!!) The plan at this point was to close the defect which was done in the clinic but the suture material used was 4-0 **nylon**. This is rarely if ever used in the oral cavity because it is irritating and also would pull through and tear tissue further compromising this defect in the mucosa.

The patient also noted heavy sanguinous discharge from his right nostril and he was given Ceclor and Actifed.

20 Jul 94
According to the note the secondary closure is described as healing well and the sutures were removed.

23 Aug 94
Patient returned with history of having swelling of the entire buccal mucosa for 2 days. His examination again noted the dehiscence. He was given bacitracin ointment presumably to be placed in the oral cavity and he was to be closed again if it remained open for 1-2 weeks. He was also to have a renewal of the Ceclor as needed if there was more swelling.

6 Sep 94
The note states that there have been no further problems with inflammation and a closure is planned for Friday under local anesthesia. There is no description of the dehiscence but its' presence is implied by the planned procedure.

9 Sep 94
The procedure note describes closing the defect under local anesthesia but the type of suture is not listed.

12 Sep 94
This note states that the patient has continued to do well with good closure to date.

21 Sep 94

Again his course is described as healing and the sutures are removed. The return was to be scheduled in 2-3 weeks.

The Oral and Maxillofacial Surgeon from Ramstein presented this patient to me and described a large defect in the mucosa overlying the previous Caldwell-Luc site and also described some potentially nonviable teeth which will require root canals at least and may require extractions. Additionally described is a large area of dead bone which will require debridement and bone grafting prior to closure of the defect. Upon review of his CT scan this patient continues to have the opacification of the right maxillary sinus which was present on his initial scan.

In summary:

We have a patient who presented to the otolaryngology clinic with HA as his chief complaint. He was treated with decongestants and he was given an allergy referral. During his work-up a CT scan was positive for **right-sided** maxillary sinus disease but was misinterpreted as being **left-sided** disease. The patient was treated with antibiotics but no post-treatment scan was ordered to assess the efficacy of the treatment. As the symptoms failed to resolve following the treatment for allergies and migraine headaches he was scheduled for a **left** endoscopic sinus procedure and a **left** Caldwell-Luc. This procedure was performed in March 1993.

The patient returned still having headaches and was sent back to the allergy clinic and was treated with immunotherapy which may or may not have improved his condition but certainly did not eliminate his headaches. A follow-up CT scan was ordered which revealed **right-sided** maxillary sinus disease and apparently the radiologist was of the opinion that the right side had been the side of the previous operation.

The patient had continued to complain of soreness in the incision site but it apparently had not been examined and almost 12 months elapsed during which time the patient was being treated for allergies. When he returned he inadvertently was seen by [redacted] where he was noted to have the mucosal defect otherwise known as an oral-antral fistula in the previous incision site. The patient was referred back to Dr Stemmer who finally acknowledged the presence of the fistula but who also was now of the opinion that the preoperative sinus disease was improved and that the patient now had sinus disease on the opposite side.

Multiple attempts at closure as an outpatient procedure apparently have failed and the defect is still present. The patient now has an oral-antral fistula on the **left** with nonviable teeth and an area of necrotic bone which will require bone grafting prior to the closure of the fistula. He will need root canals of the affected teeth and if unsuccessful, he may require extractions. This fistula is considered a complication of the original procedure which in itself is not usually a problem once it is recognized. To not be noted for 12 months is certainly not considered to be acceptable and it should have been documented and repaired much sooner than in this case.

TRUE CERTIFIED COPIES

BY

The most alarming problem in this case stems from the fact that the wrong side was operated on in the first place and Dr Stemmer is apparently still unaware that this is the case. Simply reviewing the preoperative x-rays will reveal that the disease was always on the patients' right side. So not only is there a complication from the operation but the preoperative condition and disease process has not yet been addressed and the patient still needs an operation on the right side in addition to the closure of the defect on the left.

Several alternate issues also remain:

-The described endoscopic sinus surgery is not the standard technique and does not follow the established guidelines for the procedure. Anatomic landmarks are not described nor is there a systematic approach to the diseased areas intra-operatively.

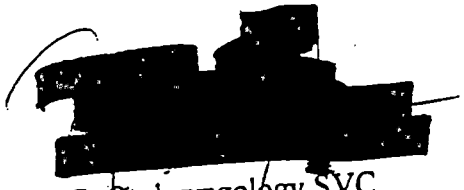
-The pathology report identifies cartilage from the antrum which is tissue not normally found in that location and fails to mention the diseased and polypoid mucosa which Dr Stemmer describes as being seen when he examined that sinus. What was actually removed from the sinus? This would suggest that he failed to understand what tissue was normal to the sinus and also that he was unable to recognize a normal sinus while directly inspecting it during the procedure. (the left maxillary sinus has always been normal on the x-rays)

-Post-operatively his examination of the patient was cursory at best and the defect went unnoticed according to the documentation for almost 12 months. This despite persistent complaints from the patient about pain and soreness in the area.

-The attempted closure according to the notes in the chart was performed using nylon sutures which would be an extremely poor choice given the location of the defect.

-The radiology report incorrectly described the site of the abnormality as being on the left side and apparently there was further confusion on the repeat scan after the procedure had been performed. Again the side was first listed as left which was then corrected to read right sided disease following a right sided procedure when the xray request lists the procedure as having been done on the left.

This patient will be examined by me and a coordinated procedure is being planned with the Maxillofacial surgeons to address his right sided sinus disease and also his postoperative complications on the left side.



C, Otolaryngology SVC
Landstuhl Regional Medical Center
10 Oct 04

TRUE CERTIFIED COPY

BY

[redacted]

 10 Oct 94

This is the complicated case of an 11yo female with chronic ear disease. This patient was referred to Dr Stemmer from [redacted] for management of her ear disease. A copy of her inpatient record is enclosed. This chart was brought to my attention by [redacted] after she was asked by the father to review her chart prior to a pending PCS move to CONUS. This case can be presented in greater detail by [redacted] who has the outpatient record for review.

The hospital chart includes a history and physical examination by Dr Stemmer which is confusing and grossly inadequate. He describes a well patient appearing her stated age but fails to mention that she has Down's syndrome. This is significant because these patiens have more problems with middle ear disease and frequently require long term PE tube placement. She is described as having a long history of chronic ear infections and Dr Stemmer states that on CT scan this may be related to chronic ethmoiditis. Her CT scans were pulled and reviewed by me and another otolaryngologist independent of my interpretation and they were interpreted as being normal with regard to the ethmoid sinuses.

This patient had undergone the placement of multiple prior sets of PE tubes which was not mentioned in the H&P which is also a pertinent part of the history. No mention is made of the preoperative audiogram which I feel should be included in the records of any patient undergoing middle ear surgery. The physical examination describes a 2 mm central TM perforation on the right. The left TM is not described. Also mentioned were polypoid changes of the right middle and superior turbinates. No impression or plan was listed on the history and physical exam form.

The patient was taken to the OR on 26 Jan 94 and underwent a "limited left ethmoidectomy" and a "right tympanoplasty." His preoperative diagnosis was "possible right and left ethmoiditis," "central and marginal perforations of the right tympanic membrane" and "infected and hypertrophied adenoids." The preoperative CT scan shows normal ethmoid sinuses which obviates the need for ethmoidectomy and eliminates the diagnosis of ethmoiditis. This patient did not need an ethmoidectomy. Her CT scan did reveal some thickening of the mucoperiosteum of the left maxillary sinus but this was not mentioned nor was it addressed. The examination describes a central perforation of the right TM but no mention is made of a marginal perforation. The preoperative diagnosis must be based on clinical findings. The adenoids are not mentioned at all in the H&P and it is unclear from the record how this became part of the preoperative diagnosis.

The operation itself as described is very confusing. A left sided TM perforation was described where previously the left side was not mentioned. It also was not listed as a postoperative diagnosis and this is a significant intraoperative finding. The premise used as the basis for the right sided TM perforation was right sided ethmoiditis despite a normal CT scan of the region. Somehow with a normal right ethmoid sinus intraoperatively Dr Stemmer was able to justify a "biopsy" of the left ethmoid sinus even in the face of what he described as "very minimal inflammation." With the facts as listed above, the "ethmoid biopsy" was not indicated and fails to substantiate his premise for the ear disease. Why was the left TM perf. not found preoperatively?

Was the left ear truly examined preop? What was the hearing level in both ears? These are all very important questions not answered in the history and examination.

With regard to the tympanoplasty, I am unable to follow the sequence of events described in the operative dictation. The technique as described was very confusing and it is unclear what exactly was done based upon the description of the procedure.

The nasopharyngeal exam was equally confusing in that his preoperative impression according to the dictation was that of infected and hypertrophied adenoids which if thought to be contributing to the ear disease means that the patient needs an adenoidectomy. Instead of performing an adenoidectomy, the adenoids were examined and left alone because he did not want to disturb the Eustachian tube on the right side!!!! If the adenoids were enlarged why not remove them? If they were not to be removed, why look at them intraoperatively at all? This part of the procedure simply does not make sense clinically and once again the question arises as to whether this procedure was indicated or not?

This chart is full of clinical uncertainties and key diagnostic tests and pertinent physical findings were notably absent. Serious questions exist concerning the appropriateness of the procedure. Although I do not agree with the premise used as the basis for this disease, if one follows the premise logically there should at least be clinical evidence that the basis for the premise does indeed exist. In other words if ear disease is to be based upon the presence of ethmoid sinus disease; ethmoid sinus disease must be present. That was not the case here radiologically, clinically or intraoperatively!

The physical exam is noticeably deficient in what are considered crucial clinical findings to include the audiogram, the status of the left ear, the actual CT findings and an assessment and plan. The documentation is extremely poor and the operative technique does not follow recognized standard techniques.

The care delivered in this case does not meet the standard of care for an otolaryngologist.

[redacted]
C, Otolaryngology Service
LRMC

[redacted]

A patient with an asymmetrical SNHL was presented to me by Dr Stemmer. The patient was to be air evacuated to WRAMC and my signature was required. The patient was an active duty soldier who was found on his retirement exam to have this hearing loss. An ABR was performed which was also abnormal.The patient was seen by Dr Stemmer and an MRI was ordered appropriately. Review of the records revealed a note in the chart stating that regardless of the results of the MRI. the patient was to be evacuated to WRAMC for further evaluation. A discussion about the work-up of this type of hearing loss took place between Dr Stemmer and myself and became obvious from the beginning that Dr Stemmer was not aware of the logical sequence of tests and which test was the most specific.

Dr Stemmer was concerned about something being missed but could not elaborate on what it was that concerned him. The MRI is the definitive test at this time with regard to the work-up for this type of hearing loss and it is used to diagnose acoustic tumors. With a normal MRI the diagnosis is eliminated. When asked why he preferred to evacuate this patient to CONUS, Dr Stemmer's only reply was that he wanted further evaluation. He was again asked what was in the differential diagnosis of this patient and he did not have an answer.

This patients' work-up at this time was complete and he did not need to be air evacuated to the states for any further testing. This was conferred to Dr Stemmer and the proposed air evacuation was canceled.

Knowledge about the work-up and diagnosis of asymmetrical SNHL is within the expected realm of care to be provided by an Otolaryngologist. It is expected that the fact that the MRI is the final diagnostic step for the diagnosis of an acoustic neuroma should be common knowledge. This would have been an unnecessary flight wasting resources and should not have even been considered.

C, Otolaryngology SVC
LRMC

[redacted]

Pt seen by Stemmer for complaints described as vertigo by referring MD also reported to have TM perf. Pt examined and according to Stemmer perf AD was confirmed. Audio reveals normal thresholds and **normal** tymps.(see copy of consult)

A nonavailability statement was requested and upon review of the DX by me, it was denied and the patient was reappointed to see me at which point on exam she was found to have **monomeric membranes** and her TM was **not** perforated.

This case was discussed with Stemmer and reluctantly he reexamined the patient and was unfamiliar with the terminology of a monomeric membrane but insisted on describing a small TM perf. He informed me that I was "splitting hairs" when I stated that a monomeric membrane should be easily recognizable by an otolaryngologist or if a question or doubt exists it should be so stated and confirmed with tympanometry or a microscopic exam.

When asked why she was referred on the economy to begin with Stemmer stated that his thought was that perhaps a repair of the "TM perf" might improve her "labyrinthitis". He was asked if he was able to perform the operation if he felt it was necessary and he replied that he was. He was then asked of the link between "labyrinthitis" and a perforated TM that was otherwise uncomplicated and he felt as though there was a link! In his note he felt that the patient had central disease which makes the evaluation even more difficult to explain. Stemmer went on to contradict himself and stated that he did not think that the perf TM was related to her vertigo.

After the discussion the patient management plan was not clear nor was it my impression that Dr Stemmer really understood what was actually going on with this patient.

[redacted]

10 Oct 94

[redacted]

LTC MC

[redacted]

ISN 7540-00-634-4178

HEALTH RECORD	CHRONOLOGICAL RECORD OF :AL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

13 SEP 1994

EAR, NOSE AND THROAT CLINIC
2nd Gen. Hosp. 486-7167
CMR-402, Box # 27
APO AE 09180

Pt seen by Dr Stemmer and dx'd as TM perf and labyrinthitis referred back after disapproval by me of unavailability statement. Pt described feeling lower extremity flushing and dysequilibrium but no vertigo

Examination: Monomeric membrane of TM A; but no perf noted

D ① Dysequilibrium
② no TM perf seen

P ① Proceed with neurology eval.
② no Tx needed to TM at present.

[redacted]
TRUE CERTIFIED COPIES
BY

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle Initial)* [redacted] SEX [redacted]

RELATIONSHIP [redacted] STATUS [redacted] RANK/GRADE

SPONSOR'S NAME [redacted] ORGANIZATION

DEPART./SERVICE SSN/IDENTIFICATION NO. [redacted] DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-8
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

16 Nov 9 Sept 11:00

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: ENT

FROM: (Requesting physician or activity) Hern ER

DATE OF REQUEST: 8-4-94

REASON FOR REQUEST (Complaints and findings)

80 yo WF c̄ vertigo and what appears to be perforated ® TM

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

At age 10 yrs had ear infection on both sides c̄ no further problems until 5-6 yrs ago began noting dizziness & some numbness of legs with abn B.P. & when seen in the ER where the finding of a perf. was first noted about one month ago with no recent antecedent ear infection. Does have occasional sinus infections and frequent occipital HA. Pt. describes episodes of awakening in the night and/or dizzy & vomit as well as everyone at the same time & does not use alcohol, but does smoke is mainly light headed. Medication [illegible] (AD) doesn't work. See normal audiogram.

Ex Normal canals & TMs AU except for dry c̄ perf. AD in [illegible] Nas. Hi erry. Hi palter c̄ [illegible] [illegible]

Impr. 1) Possible central not peripheral labyrinthitis. 2) ? associated perf. AD TM. 3) Allergic Rhinitis

R 1) Pt. to Unit Phys. to give a trial of [illegible] of its allergies [illegible] to [illegible] possible central [illegible] and will try [illegible] Agree [illegible] through the Champus program - if not successful [illegible] general ENT [illegible] the [illegible]

DATE

REGISTER NO. | WARD NO.

IDENTIFICATION NO. | ORGANIZATION

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-
Prescribed by GSA/ICMR
FPMR 101-11.806-8
513-107

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

LARMC, ER, BIAA 8414/8415
Home Phone [redacted]
NAME [redacted] DOB [redacted]
RANK SSG
SSN [redacted] UNIT 37 Trans APO 09227
SPON [illegible]
DUTY PH [redacted] REC KEPT Landstuhl

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BY

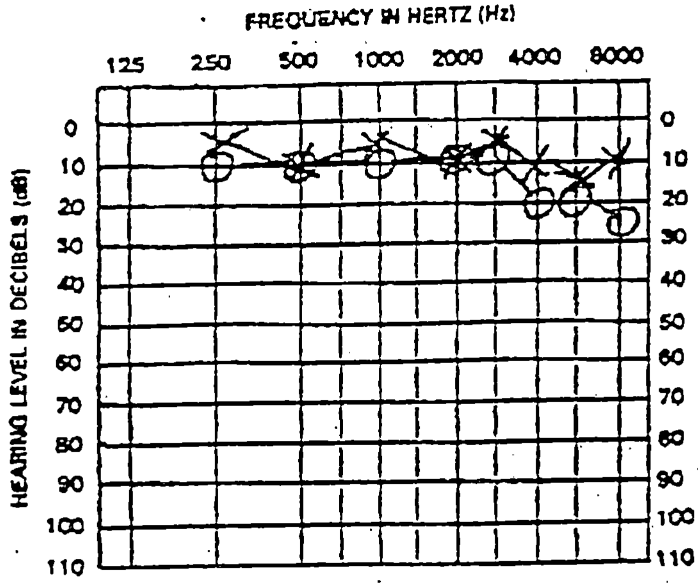
L RECORD – SUPPLEMENTAL MEDI TA

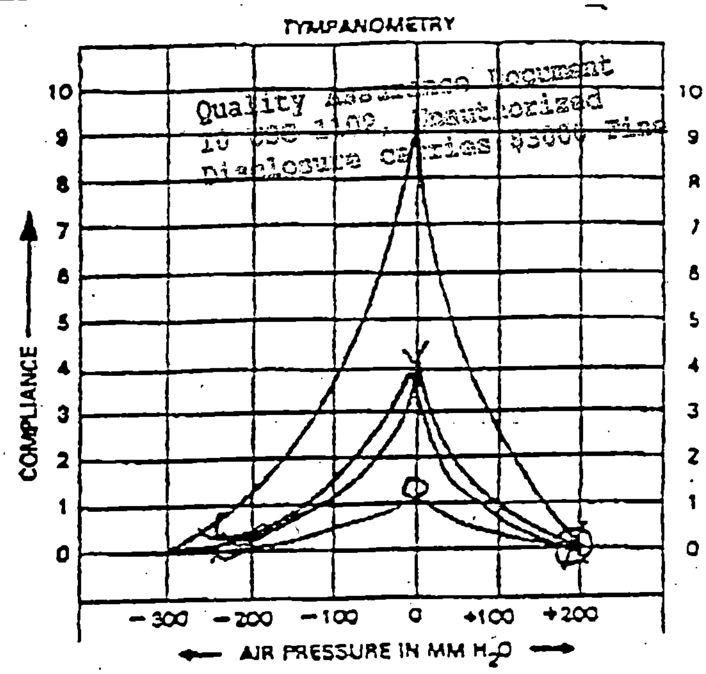
For use of this AR 40-400; the proponent agency is the Offi he Surgeon General.

REPORT TITLE

AUDIOLOGICAL EVALUATION RECORD

OTSG APPROVED (Date) 17 AUG 82





EFFECTIVE MASKING

	R	L	R	L	R	L	R	L	R	L	R	L	R	L
AC														
BC														

SPEECH AUDIOMETRY

	SAT	SRT	DISCRIMINATION %	SL	MASK
LEFT		5	92	45	
RIGHT		5	96	45	
SOUND FIELD					

SPECIAL TESTS

TEST	METHOD	Hz			
		L			
		R			
		L			
		R			

AUDIOGRAM KEY

	R	L
AC	○	X
MASK	△	□
BC	<	>
MASK	[	]
NR	↙	↘
SOUND FIELD	$	

AUDIOMETER GSI-10

RELIABILITY Good

STANDARD ANSI 1969

ELECTROACOUSTIC CALIBRATION YEAR MONTH DAY 93 09 22

CONTRALATERAL STAPEDIUS REFLEX (HL)

PHONE	500 Hz	1000 Hz	2000 Hz	4000Hz
LEFT				
RIGHT				

IPSILATERAL STAPEDIUS REFLEX

PROBE	500 Hz	1000 Hz		
LEFT	90	80	80	80
RIGHT	90	90	90	90

REFLEX DECAY

PHONE	500 Hz	1000 Hz
LEFT		
RIGHT		

PHYSICAL VOLUME

LEFT	1.0	CC	See SF600
RIGHT	1.1	CC	See Consult

[redacted]

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] CPT, MS AUDIOLOGY

DEPARTMENT/SERVICE/CLINIC "LARMC/AUDIOLOGY"

DATE 7 Sep 94

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

[redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, 1 MAY 78

AEM FORM 455-R, 1 SEP 82
7th MEDCOM REG 40-20

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BY

HEALTH RECORD | CHRONOLOGICAL RECORD OF M[illegible]AL CARE

DATE	SYMPTO[illegible], DIAGNOSIS, TREATMENT, TREATING O[illegible]ANIZATION *(Sign each entry)*
	"LARMC/AUDIOLOGY"
	S. 30 yo ♀ here for hearing eval due to possible TM perf AD. Pt c/o ear pain AD. ⊖ tinnitus AU intermittently. ⊕ dizziness occasionally x several yrs.
	Pt. was referred by the ER.
	O. see audiogram this date
	A. Normal hearing AU. Reduced TM compliance AD, normal tymp AS. Reflexes-wnl AU. Excellent discrim.
	P. Pt has ENT appt for follow-up

Quality Assurance Document 10 USC 1102, Unauthorized Disclosure carries $3000 Fine

[redacted]
CPT, MS
AUDIOLOGY

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

[redacted]
44 F DU AD USA
[redacted]

RECORDS MAINTAINED AT:			
PATIENT'S NAME *(Last, First, Middle initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

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PEER REVIEW RECORD 14 SEP 94

PCE FILE#: [redacted]

This case was reviewed by the Otolaryngology Service Peer Review Committee on 7 September 1994. Dr. Stemmer was allowed to present his interpretation of the case based on the limited available records.

This case was reviewed and to summarize the case this patient was seen in the ENT Clinic by Dr. Stemmer where upon examination the patient found a crust on the right tympanic membrane. This patient was already known to have a progressive hearing loss of the sensorineural type involving the left ear. She had also been diagnosed with a loss on the right side and on recent audiometric testing the right ear appeared to be worsening. The audiogram is not available for review but according to the consult request by the audiologist a mixed loss had developed in the right ear indicative of a conductive component to her hearing loss and she was referred for evaluation. This patient had apparently undergone surgery in the right ear in the past according to the note by Dr. Stemmer. No records were available for his review.

When Dr. Stemmer examined the patient and found the crust he elected not to remove this crust and decided to air evacuate this patient back to Walter Reed Army Medical Center for further treatment feeling that her eighth cranial nerve was degenerating further. Apparently for some reason the patient was referred out on the German economy for an evaluation by a German Otolaryngologist who after examination, removed this crust and this eliminated the conductive component to her hearing loss thereby improving her hearing back to its' previous level.

The question posed to Dr. Stemmer was why the crust was not removed during his examination. Both members of the peer review committee agreed that as part of the initial evaluation and physical examination it would be essential to remove the crust in an attempt to further define this patients' condition and in this case this would have lessened the concern about further degeneration and would have solved the problem. According to Dr. Stemmer he elected not to remove the crust for fear of further damaging the ear.

There was no adverse patient outcome. The care delivered was felt to be a marginal deviation from the standard of care and it was felt to be provider related in that thorough examinations of the ear require removal of crusts and debris in order to render an accurate diagnosis.

LESSONS LEARNED:
The practice of examining ears and not removing crusts was discussed as it prevents a complete evaluation and diagnosis and in this case could have led to an unnecessary trip to another medical treatment facility.

BY TRUE CERTIFIED COPIES

By not completely examining the ear a serious condition could have gone unrecognized. Had the crust been removed and the audiogram been repeated. it would have been clear that this suspected worsening in her hearing was in fact due to the presence of this crust.

[redacted]
C, Otolaryngology SVC
LRMC

INTERNAL PEER REVIEW: 14 SEP 94

[redacted]

This case was thoroughly discussed by the peer review committee and several points were noted It became clear that Dr. Stemmer does not feel comfortable with ear patients. It appeared that he was unable to distinguish an eighth nerve loss from a conductive loss. The request from the audiologist clearly stated that the right ear was now demonstrating a mixed hearing loss. Dr. Stemmer failed to mention the audiometric findings in his notes and was concerned about further degeneration of the eighth nerve but did not investigate the conductive component. His explanation for why he failed to remove the crust is difficult to understand but he stated that he did not want to further damage the hearing.

As a side discussion the diagnosis of cholesteatoma was discussed and it became clear that Dr. Stemmer does not know how to diagnose this disease. It is his feeling that this is an x-ray diagnosis and that it can not be made clinically. It was pointed out to him that the presence of a crust is very suspicious for cholesteatoma and by removing it if the characteristic findings are present the diagnosis can be made on the spot without the need for x-rays. In this case a potential cholesteatoma could have been missed. It also was noted that a large crust could cause a conductive hearing loss and with its' removal this hearing loss could be reversed. That is precisely what appears to have happened in this case.

The discussion and Dr. Stemmer's responses seriously questions his ability to handle these types of patient problems. His reluctance to completely examine the patient's ear and clean out the crust delayed the diagnosis and nearly led to an unnecessary trip back to Walter Reed.

Dr. Stemmer's clinical competence specifically with regard to the examination, diagnosis and treatment of chronic ear disease is questioned.

[redacted]
C, Otolaryngology SVC
LRMC

TRUE CERTIFIED COPIES

BY

486 7267/82

MEDICAL RECORD | Patricia C. Newton **CONSULTATION SHEET**

REQUEST CCA

TO: ENT.

FROM: (Requesting physician or activity) MD

DATE OF REQUEST: 3 March 94

REASON FOR REQUEST (Complaints and findings): EMO PP [illegible] pt. [illegible]. Above child has 14 yr old female c h/o gradual hearing loss. At one time had normal hearing in the left ear but gradually dropped to moderate loss - [illegible] loss (L). Hearing recently has dropped to a severe profound mixed loss in the right ear. Now has a type A (shallow) tymp. Has to turn hearing aid full volume to get gain.

PROVISIONAL DIAGNOSIS

Patricia C. Newton
DOCTOR'S SIGNATURE

APPROVED EAR, NOSE AND THROAT CLINIC
2nd Gen. Hosp. 486-7167
CMR-402, Box # 27
APO AE 09180

PLACE OF CONSULTATION: BEDSIDE / ON CALL

ROUTINE / TODAY / 72 HOURS / EMERGENCY

[illegible]
please call me
486-7299

CONSULTATION REPORT

Fugia to ENT 31 March at 11:10

3:30 4 March -

Mother states child had normal hearing until age 3 or 4 yr, but at age 5 yr. Parents noted H. loss & had Audio which showed loss on left which became progressive. At age 6 yr. pt had sig. 6 mos later Rt. sided H.L. noted. At age [illegible] of her hearing on the Rt side she had some stabilization even though her condition was allegedly not [illegible] surgeon (Mo will obtain report). At age 9 yr she was sent to WRAMC for testing & pt was told prob. is 8th [illegible] malfunction. (Copies of these reports are in Mother's possession & will be brought in.) Mo. says hearing had been stable up until last tested in [illegible], but most recent one shows further loss. (See both audios) Pt. reports no H.A. etc.

E: AD. Cerumen & debris in lower half of heavily scarred TM. [illegible]
to recd. A.S. TM & Canal [illegible]

SIGNATURE AND TITLE: Furthest to H. dep. [illegible] WRAMC. [illegible]
Pl: 1) Pt. to be followed [illegible] at [illegible]
[illegible]

DATE: MAR 1994

IDENTIFICATION NO | ORGANIZATION | REGISTER NO | WARD NO

PATIENT'S IDENTIFICATION

(H) 6371-4486
(D) 480-5130 (TDY [illegible])
(M) 480-3018

[redacted]

D/DAD/AF SSG,
Sponsor SSG [illegible]
520-F-S, F.C.1 [illegible], AE 09009

[redacted]

[redacted]

CONSULTATION SHEET
STANDARD FORM 513 (Rev 9-77)
Prescribed by GSA, ICMR
FPMR 101-11.806-8
513-107

TRUE CERTIFIED COPIES

INTERNAL PEER REVIEW: [redacted]

A comprehensive discussion took place about this case and its management. During the discussion several worrisome concerns were uncovered. Dr. Stemmer was asked to present this case as he saw it from his review of the medical record and it became quite clear during the discussion that Dr Stemmer was unable to interpret basic audiometry. He was unable to discern a conductive hearing loss from a sensorineural loss or a mixed hearing loss which in this case was very important. He also was unable to interpret which ear was being tested despite the presence of a symbols key included as a part of the audiogram. He felt that an audiologist was needed in order to decide what the test actually represented. This is considered basic knowledge that all otolaryngologists should possess and Dr. Stemmer's ability was noticeably deficient.

The fact was also discussed that given a patient with presumed chronic ear infections and its potential for causing inner ear complications (i.e.: vertigo, sensorineural losses) if a symptom of vertigo were described especially with a sensorineural loss, this might well indicate a complication of the infection and that the prudent course of action would be to eliminate the infection as a possible source for this complaint which would mean that the patient's surgery should be expedited. Even though this might not change the outcome this might be the only way to try and avoid the long term effects from a complication of otitis media. Both members of the committee agreed that the recommended treatment plan at that point would be to insert the tubes. Dr. Stemmer in his review of the case did not feel that this was warranted and did not seem to even understand the possible connection between otitis media and inner ear disease.

A more disturbing part of his review was his interpretation of the case and its' outcome. Dr. Stemmer composed a memorandum explaining why he thought the patient lost his hearing. Despite the presence of grossly abnormal preoperative audiograms suggesting a sensorineural loss in the patient's right ear, Dr. Stemmer stated in his memo that the hearing loss was directly attributable to the PE tube placement by [redacted] He went on to say that this occurrence was not outside of the known rate of expectation for this surgery. In fact to cause a hearing loss of this type from PE tube insertion would be considered a significant complication of the surgery. This further displays Dr. Stemmer's inability to process available data and also calls in to question his knowledge of chronic and acute ear disease.

The documentation deficiencies were highlighted with regard to the physical examination, the subjective complaints, and the objective data most notably the audiometric findings.

The presumed correlation between tonsillar disease and middle ear disease was then addressed and after questioning, Dr. Stemmer stated that he did not feel there was a correlation but when asked about his notation in the medical record which clearly states the patient is listed for tonsillectomy he felt that his note was being misinterpreted. In actuality the note as written was quite clear and it could only be interpreted in one way. It was the feeling of the committee that Dr. Stemmer was of the opinion that there indeed was a correlation.

The discussion of this case and the presentation of his interpretation by Dr. Stemmer raises serious concerns about his basic skills and his fund of knowledge. His inability to accurately interpret basic audiometry is quite alarming and brings up the issue of competency

C, Otolaryngology SVC
LRMC

PEER REVIEW RECORD

14 SEP 94

Quality Assurance Document
USC 1102, Unauthorized
Disclosure carries $3000 Fine

PCE FILE#: [redacted]

This case was discussed by the Otolaryngology Service peer review committee on 7 September 94 and it concerns a malpractice claim filed on behalf of [redacted] The medical record was reviewed by both members of the committee independently and the case was then discussed. Dr. Stemmer was allowed to present his interpretation of the case after review of the medical records.

In summary this patient had a long history of recurrent ear infections dating back to before any care was delivered at Landstuhl Regional Medical Center. There were no audiograms in the record prior to July 1991 so the status of his hearing prior to that time is unknown. In reviewing the audiograms in the medical record it is important to note that **none** of the audiograms were normal. It appears as though a fairly significant hearing loss existed in his right ear at the time of his initial audiogram here at Landstuhl. There is a conductive component probably due to the presence of fluid in the middle ear on both sides however the right side is noted to have a considerable sensorineural component as well. This finding exists in multiple audiograms throughout the medical record.

During [redacted] evaluation and work-up he was treated by several physicians prior to his being seen in the ENT clinic. This is the normal case in patients with this diagnosis. During his initial evaluation in the ENT clinic in JAN 91 by [redacted] his examination was documented and he was treated with antibiotics and if his condition recurred he was to have PE tubes placed. He continued to have infections despite antibiotic treatment and he was referred back to the ENT clinic. During this time his audiograms continued to be abnormal. He was next seen by [redacted] who concluded that [redacted] needed PE tubes. The date of this visit is unknown but it was sometime after the consult was written by the pediatrician in MAY 91. [redacted] does not mention a hearing loss or the audiometric findings which were first noted in the chart on 22 JUL 91.

While waiting for the surgery the patient continued to have problems and a telephone call was made by the mother to the pediatrics clinic on 27 AUG 91 where [redacted] was described as staggering and falling down. The mother apparently was instructed to bring him in to be seen the following day, 28 AUG 91, at which point his neurological exam by the pediatrician was described as normal with no evidence of vertigo or nystagmus. The claim states that a call was then made to the ENT clinic however it is not documented in the record. Nonetheless the patient was seen the next day, 29 AUG 91 , by Dr. Stemmer in the ENT clinic. During that examination there is no mention made of vertigo or a neurological examination and Dr. Stemmer agrees with the plan for PE tubes and also lists the patient for tonsillectomy and adenoidectomy. Dr. Stemmer also failed to mention any audiometric findings or hearing loss.

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BY

Because of the surgical backlog the procedure was not done prior to [redacted] next visit with Dr Stemmer on 10 OCT 91 where he describes the patient as doing better on decongestants. It is unclear at this point what happened during that clinic visit. The claim alleges that again the tubes were postponed but the note indicates only that the patient was to be reevaluated after repeat audiometric testing and he was referred to the allergy clinic. There was no mention of surgery being canceled or postponed.

[redacted] was seen several more times by the Pediatrics Department and a "second opinion" was requested according to the record but there were no clinic notes by the ENT clinic until 21 NOV 91 when the patient underwent placement of PE tubes and removal of his adenoids.

The audiograms done postoperatively show improvement in the conductive component of his hearing loss however the sensorineural component which was also present did not change. This was the expected outcome.

The placement of PE tubes is controversial and the subject of much debate. It is left to the Otolaryngologist to decide when the tubes are recommended and in this case that recommendation was first made by [redacted] some time after MAY 91. There is a tremendous demand for this type of surgery and for that reason a backlog frequently exists. When the backlog becomes excessive, we frequently rely on the local physicians for placement of PE tubes and removal of adenoids. For some reason this was apparently not done in this case. This was also during the time of the Gulf War which affected the availability of care especially for dependents.

During the interval while [redacted] was waiting for surgery a complaint of vertigo arose. Once this was brought to the attention of the physicians taking care of him, he was appropriately seen and his neurological exam was reported as normal. The documentation by the Otolaryngologist was poor as to whether or not he was aware of this complaint and whether or not there were any clinical signs to support this complaint. Once again the audiometric findings were not documented. Both members of the peer review committee agree that if a question arose regarding the possibility of vertigo and sensorineural hearing loss which would indicate labyrinthine symptoms, or a complication of acute otitis media, PE tubes would probably have been placed expeditiously. After reviewing the audiograms it appears that the hearing loss already existed so earlier tube placement would probably not have affected the hearing outcome.

In the claim a statement was made about the clinical privileges of Dr. Stemmer being suspended during the time [redacted] was awaiting surgery. Such was not the case and in fact [redacted] already had placed [redacted] on his surgery list and was the physician who actually performed the surgery. As previously mentioned [redacted] had a documented hearing loss early on in his treatment and whether this was related to the time it took until the PE tubes were placed will never be known. In the general population hearing losses occur in 1:1000 children and this could very well have been a congenital loss.

CONCLUSIONS:
The standard of care was met. This was not provider related and was probably was not preventable.

LESSONS LEARNED:
The documentation by the identified Otolaryngologist was notably poor regarding the question of vertigo and hearing loss. This issue was addressed. The documentation by other Otolaryngologists was also notably poor with regard to the audiometric findings and the fact that these findings are crucial and need to be documented in the records was stressed.

The inherent time interval between the diagnosis of chronic serous otitis media and PE tube placement was also discussed and currently because of the prolonged time interval these patients are referred out on the local economy for this type of surgery to avoid long delays.

Another issue addressed was the proposed correlation between tonsillar disease and ear disease as indicated by the patient being listed by Dr. Stemmer for tonsillectomy along with adenoidectomy and PE tube placement. The fact that there is no literature in support of this correlation was reiterated and the point was stressed that this patient did not need a tonsillectomy.

C, Otolaryngology SVC
Landstuhl Regional Medical Center

[redacted]

Pt with bilat SNHL sent to neurology for ? reason (see copy)

From the audiometric standpoint this appears to be a straight forward case of HFSNHL. The workup would normally be done by the otolaryngologist and unless special circumstances exist, neurology would not be involved.

Cat is unclear from the record why she was referred to neurology.

[redacted]

10 Oct. 94

[redacted]

TC MC 27[illegible]-8597

TRUE CERTIFIED COPIES

BY [signature]

[redacted]

Apr 94

pt with hoarseness [illegible] ENT clinic found to have a (L) TVC lesion after exam by Dr Stormer. The lesion was described as a "(L) TVC lesion with sub-glottic extension". While a lesion is described in that manner, cancer is the number one thing on the list. This pt has an extensive smoking history which supports the risk of cancer.

Because this pt was a dependent, he was placed on the waiting list. He was advised to seek care through champus.

He was not seen again until Aug 94 when upon re-exam the lesion had still not been addressed. He had been seen on the evening list due to scheduling delays. He was still waiting for surgery. Dr Storm[illegible] presented the pt to me at which time [illegible] removed the lesion

unfortunately it was not a cancer.

the concern here stems from the fact that yes the pt was a dependent but regardless of his status, with the lesion as described, his care needed to be expedited. Dr Stormer was unable to to understand that the pt status cannot always dictate how the pt is to be handled. the disease process is what determines the urgency here.

[redacted]
10 Oct 94

MEMORANDUM FOR RECORD

Quality Assurance Document
10 USC 1102, Unauthorized
Disclosure carries $3000 Fine

28 July 1993

This MFR is to document the difficulties I encountered in attempting to refer a patient, [redacted] to the ENT Service at Landstuhl Army Regional Medical Center while the patient and I were both deployed to Zagreb, Croatia with the 502nd MASH.

I treated [redacted] a CRNA with the 502nd MASH, for a lateral pharyngeal abscess secondary to tonsillitis in May 1993. While she was recovering from an I & D of the right lateral pharyngeal abscess, I called the ENT Service at LARMC to discuss her referral for evaluation and treatment of her chronic tonsillitis. I spoke with LTC Stimmer. After hearing my description of her case, he agreed that tonsillectomy was indicated after approximately 6 weeks of recovery from the I & D. However, he said that no appointments were available. After asking that her case be given some priority since she was deployed to Croatia and she was a key and essential staff member of the hospital who would require replacement, LTC Stimmer told me that no priority was warranted just because she was deployed. He told me that everyone assigned in Europe was "deployed". I disagreed with him and continued insisting that she should be seen expeditiously because of the adverse effect of her possible continued tonsillitis on the mission of the 502nd MASH. He was totally uncooperative and unprofessional, but finally told me to mail him a consult and he would get back to me. I did as he asked and included my telephone and FAX numbers on the consult. I also kept a copy of the consult. After two weeks, I had not heard from him and I called him back. Initially, he claimed he did not recall our previous conversation. After I described the conversation in detail, he told me to hold on and he would look for the consult. He returned to the phone after several minutes and explained that the reason he never answered my request was because I did not include a phone or FAX number for him to call. I asked him if he was actually looking at my consult and he said yes and that there were no phone or FAX numbers on the consult. I then told him I was holding my copy of the consult and that my copy included the numbers. There was silence on the line for a few moments and then I told him I did not appreciate being lied to and that if he did not cooperate and help my patient. I was going to go up the chain of command. He said that he would call me back within a day. The following day I received a FAX message with an appointment for [redacted] to be seen in Landstuhl. Arrangements were made for another military CRNA to deploy to Zagreb in her absence and she was evaluated and underwent tonsillectomies at Landstuhl later in the summer. At [redacted] and my request, she was treated by a different ENT surgeon, not LTC Stimmer.

[redacted]

LTC, DC
Oral & Maxillofacial Surgeon

TRUE CERTIFIED COPIES

BY [redacted]

DEPARTMENT OF THE ARMY
502ND MOBILE ARMY SURGICAL HOSPITAL
OPERATION PROVIDE PROMISE
APO AE 09779
ZAGREB, CROATIA

15 May 1993

DISCHARGE SUMMARY

PATIENT: [redacted] HOSPITAL REGISTER NUMBER: 54

SOCIAL SECURITY NUMBER: [redacted]

NATIONALITY: United States (502ND MASH)

DATE OF ADMISSION: 11 May 1993 DATE OF DISCHARGE: 15 May 1993

CHIEF COMPLAINT: Pain, right throat

HISTORY: This 36 year old USA CPT was admitted to the Oral and Maxillofacial Surgery Service with an early right lateral pharyngeal infection which began 5 days before with pharyngitis and then tonsillitis. She had been placed on penicillin po and then also metronidazole po, but had not improved. There was mild dysphagia, but no dyspnea. The patient was missing all third molars.

PAST MEDICAL HISTORY: Tonsillitis with 3 episodes in last 3 years which had resolved on po antibiotics. Occasional smoking and alcohol use. Past surgeries: none. Previous injuries: Closed head injury, 1982 with no sequelae. Current medications: penicillin VK, 500 mg po q6h ; metronidazole, 500 mg po q8h; ibuprofen. Drug allergies: IV contrast media. Social history: Patient is a CRNA.

REVIEW OF SYSTEMS: Noncontributory except dysphagia

PHYSICAL EXAMINATION: Well developed, well nourished white female in mild distress due to pain in throat. Vital signs: BP 110/70, P-79, R-17, T-98.6 F. HEEN exam was normal, except there was minimal trismus with maximum interincisal opening of 17 mm. Examination of the throat revealed slight edema and erythema of the right oropharynx. The uvula was very minimally deviated toward the left. There was mild tenderness and lymphadenopathy in the right neck superior to the hyoid and anterior to the sternocleidomastoid border. Other than vitiligo on both hands, the remainder of the physical examination was normal.

LABORATORY AND X-RAY STUDIES: Soft tissue radiographs of the neck revealed no retropharyngeal edema. There was slight lordotic cervical positioning. CBC was normal with white blood count of 10.9 with normal differential.

HOSPITAL COURSE: After admission, IV penicillin, 3 million units q4h and IV metronidazole, 500 mg q6h was immediately begun and the

patient was carefully observed for any airway compromise. Pediatrics secondary to initial diagnosis was right lateral pharyngeal cellulitis secondary to tonsillitis. On the second hospital day, the patient was feeling better with decreased dysphagia. She remained afebrile and the uvula was midline. However, by early morning of the third hospital day, there was increasing dysphagia and slightly increased right lateral pharyngeal edema. After appropriate preoperative counseling and consent, the patient was taken to the Operating Room where an intraoral incision and drainage of the right lateral pharyngeal abscess was performed. Postoperatively, there was no airway compromise, so the patient was extubated in the OR. IV cefazolin, 1 gm q8h was substituted for penicillin and IV metronidazole was continued postoperatively. Subsequent culture results revealed Staphylococcus species resistant to penicillin, but sensitive to cephalosporins. The patient improved rapidly and the penrose drain was removed on postoperative day one. IV antibiotics were discontinued on postoperative day two and cephalexin, 500 mg po q6h and metronidazole, 500 mg po q6h were begun. On 15 May 1993, the patient was discharged in good condition with a recommendation for one week of unit convalescent leave.

DIAGNOSIS: Right lateral pharyngeal abscess secondary to tonsillitis

SPECIAL PROCEDURES AND OPERATIONS: 13 May 1993 - Intraoral incision and drainage, right lateral pharyngeal abscess

DISPOSITION: On 15 May 1993, [redacted] was discharged to duty in much improved condition. Discharge medications were cephalexin, metronidazole and Tylox. She was on a soft to regular diet. Follow-up was planned in the Oral and Maxillofacial Surgery Clinic in two days. Telephone consultation was also planned with the ENT service at Landstuhl Army Medical Center in Germany to discuss possible referral for tonsillectomy in the near future.

[redacted]
LTC, DC
Oral and Maxillofacial Surgeon

TRUE CERTIFIED COPIES
BY

MEMORANDUM FOR RECORD

28 July 1993

This MFR is to document the difficulties I encountered in attempting to refer a patient, [redacted] to the ENT Service at Landstuhl Army Regional Medical Center while the patient and I were both deployed to Zagreb, Croatia with the 502nd MASH.

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[redacted]

[redacted]

LTC, DC
Oral & Maxillofacial Surgeon

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BY [redacted]

HEALTH CARE PROVIDER ACTION REPORT

1. DATE OF REPORT (YYMMDD): 95 02 24 | REPORT CONTROL SYMBOL: DD-HA(AR)1288

Quality Assurance Document
10 USC 1102, Unauthorized
Disclosure carries $10000 fine

2. TYPE OF REPORT (X one)

a. INITIAL	b. CORRECTION OR ADDITION	c. REVISION TO ACTION	d. VOID PREVIOUS
	X		

3. DATE OF ACTION (YYMMDD)	4. EFFECTIVE DATE OF ACTION (YYMMDD)	5. MEDICAL TREATMENT FACILITY (MTF) a. NAME AND ADDRESS (Street, City, State, ZIP Code)	b. DMIS CODE
95 02 23	95 02 23	Landstuhl Regional Med Cen CMR 402 APO AE 09180	607

6. PROVIDER INFORMATION

a. NAME (Last, First, Middle)	b. SSN	c. DATE OF BIRTH (YYMMDD)
STEMMER, August L.	[redacted]	[redacted]

d. NAME OF PROFESSIONAL SCHOOL ATTENDED		e. DATE GRADUATED (YYMMDD)
Harvard Medical School	X (1) UNITED STATES (2) FOREIGN	55 06 16

f. STATUS (X one)

X (1) Army	(3) Air Force	(5) Civilian GS	(7) Partnership External	(9) Non-Personal Services Contract
(2) Navy	(4) PHS	(6) Partnership Internal	(8) Personal Services Contract	

g. SOURCE OF ACCESSION (X all that apply)

(1) Military	(2) Civilian	h. PAY GRADE
X (a) Volunteer	(a) Civil Service	0-5 (LTC)
(b) Armed Forces Health Professional Scholarship Program	(b) Contracted	
(c) Uniformed Services University of Health Sciences	(c) Consultant	i. FEDERAL DEA NUMBER (If known)
(d) National Guard	(d) Foreign National (f at hire)	
(e) Reserve	(e) Other (Specify)	
(f) Other (Specify)		

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j. LICENSING INFORMATION

(1) State of License	(2) License Number	(1) State of License	(2) License Number
California	GFE 6854		

7. TYPE OF PROVIDER AND SPECIALTY (FIELD OF LICENSURE) (X all that apply)

a. PHYSICIAN DEGREE: X M.D. (010) | D.O. (020)

(1) Highest Level of Specialization: X (a) Board Certified | (b) Residency Completed | (c) In Residency (015/025) | (d) No Residency

(2) Primary Specialty

(a) In Training	(h) Internal Medicine (Cont.)	X (l) Otorhinolaryngology	(t) Surgery, General (Cont.)
(b) General Practice (GMO)	(h.c) Infectious Disease	(m) Orthopedics	(t.d) Oncology
(c) Anesthesiology	(h.d) Nephrology	(n) Pathology	(t.e) Pediatric
(d) Aviation Medicine	(h.e) Pulmonary	(o) Pediatrics	(t.f) Peripheral Vascular
(e) Dermatology	(h.f) Rheumatology	(p) Physical Medicine	(t.g) Plastic
(f) Emergency Medicine	(h.g) Tropical Medicine	(q) Preventive Medicine	(u) Undersea Medicine
(g) Family Practice	(h.h) Allergy/Immunology	(r) Psychiatry	(v) Urology
(h) Internal Medicine	(h.i) Cardiology	(s) Radiology	(w) Intensivist
(h.a) Gastroenterology	(h.j) Endocrinology	(t) Surgery, General	(x) Neonatologist
(h.b) Hematology-Oncology	(i) Neurology	(t.a) Cardio-Thoracic	(y) Other (Specify)
	(j) Obstetrics/Gynecology	(t.b) Colon-Rectal	
	(k) Ophthalmology	(t.c) Neurosurgery	

(3) Board Certification(s): American Board of Otolaryngology

b. DENTIST: DENTIST (030)

(1) Highest Level of Specialization: (a) Board Certified | (b) Residency Completed | (c) In Residency (035) | (d) No Residency

(2) Primary Specialty: (a) General Dental Officer | (b) Oral Surgeon | (c) Other (Specify)

(3) Board Certification(s)

c. OTHER PROVIDERS

Audiologist (400)	Nurse Anesthetist (110)	Optometrist (536)	Registered Nurse (100)
Clinical Dietician (200)	Nurse Midwife (120)	Physical Therapist (430)	Emergency Medical Technician
Clinical Pharmacist (050)	Nurse Practitioner (130)	Physician Assistant (542)	Other (Specify)
Clinical Psychologist (370)	Occupational Therapist (410)	Podiatrist (350)	
Clinical Social Worker (300)		Speech Pathologist (450)	

8. ACTION TAKEN

a. PRIVILEGING ACTIONS TAKEN / REASON CODE (See Page 3, Item 14a)	b. ACTIONS OTHER THAN PRIVILEGING (ADMINISTRATIVE) / REASON CODES (See Page 3, Item 14b)	c. LENGTH OF ACTION (In months)
610.02		Permanent
	Quality Assurance Document 10 USC 1102, Unauthorized Disclosure carries $3000 Fine	
☐ NONE	☐ NONE	

d. LIST HOW AND WHY WHAT PRIVILEGES ARE AFFECTED BY THE ACTION:

Provider's clinical privileges in otolaryngology and maxillo-facial surgery at Landstuhl Regional Medical Center are revoked based on incompetence. Hearing Committee reviewed all evidence presented and recommended continued revocation of privileges. Provider was advised of right to appeal to USA MEDCOM.

e. OTHER ACTIONS TAKEN (X all that apply)

☐	(1) Review	☐	(2) Rehabilitation	☐	(3) Retraining	☐	(4) On-the-Job Training	☐	(5) Separated for Cause
☐	(6) Fired / Terminated	☐	(7) Separated	☐	(8) Resigned	☐	(9) Retired	☐	(10) Other

9. CIVILIAN CONTRACTOR NAME

10. PROVIDER'S LAST KNOWN ADDRESS OR HOME OF RECORD (Street, City, State, and Zip Code)	11. MEDICAL TREATMENT FACILITY (MTF) POINT OF CONTACT	
	a. NAME (Last, First, Middle Initial)	b. TELEPHONE (Include Area Code)
LRMC: CMR 402, Box 11 APO AE 09180	APO AE 09180	[redacted]

12. REMARKS

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13. OFFICE OF THE SURGEON GENERAL (OTSG) INDIVIDUAL SUBMITTING COMPLETED REPORT

a. NAME (Last, First, Middle Initial)	b. TITLE	c. TELEPHONE

d. ADDRESS	e. SIGNATURE	f. DATE SIGNED (YYMMDD)
Office of the Surgeon General		

INSTRUCTIONS

(All other items are self-explanatory.)

2b. Correction or Addition: An administrative change intended to supersede or add information to the contents of a current version of a report.

2c. Revision to Action: A new action which is related to and modifies a previously submitted adverse action.

3. Date of Action: Enter the date of formal approval of the MTF's action as indicated by the OTSG.

4. Effective Date of Action: Enter the date on which the action became effective.

14a. Privileging Actions Taken / Reason: This entry is equivalent to NPDB's Adverse Action Classification Code.

HEALTH CARE PROVIDER CLINICAL PRIVILEGES ACTION REPORT

(Shaded areas for OTSG information only.)

1. DATE OF REPORT (YYMMDD)	REPORT CONTROL SYMBOL
941104	Assumable Document IAW MEDCOM 3102

Disclosure carries $3000 Fine

2. TYPE OF REPORT (X one)

a. INITIAL	b. CORRECTION OR ADDITION	c. REVISION TO ACTION	d. VOID PREVIOUS REPORT
		X	

3. DATE OF ACTION (YYMMDD)	5. MEDICAL TREATMENT FACILITY	
941102	a. NAME: Landstuhl Regional Medical Center	b. ADDRESS (Include Zip Code and Country if not U.S.): ATTN: AEMLA-QA (Cliff Wagner, CPHQ) APO AE 09180-3460
4. EFFECTIVE DATE OF ACTION (YYMMDD) 941102	c. DMIS CODE	

6. PROVIDER INFORMATION

a. NAME (Last, First, Middle Initial, Suffix)	b. SOCIAL SECURITY NUMBER	c. DATE OF BIRTH (YYMMDD)	d. SEX
STEMMER, AUGUST L.	[redacted]	[redacted]	M

e. NAME OF PROFESSIONAL SCHOOL ATTENDED		f. DATE GRADUATED (YYMMDD)	g. STATUS (X one)	
Harvard Medical School	X (1) United States; (2) Foreign	55/06/16	X (1) Army; (2) Navy	(3) Air Force; (4) PHS; (5) Civilian

h. SOURCE OF ACCESSION (X all that apply)

(1) Military	(2) Civilian
X (a) Volunteer	(a) Civil Service
(b) Armed Forces Health Professional Scholarship Program	(b) Contracted
(c) Uniformed Services University of Health Sciences	(c) Consultant
(d) Ready Reserve of the National Guard or Reserve Components	(d) Foreign National (Local hire)
(e) Other (Specify)	(e) Other (Specify)

TRUE CERTIFIED COPIES BY

i. PAY GRADE	j. YEARS OF FEDERAL SERVICE	k. FEDERAL DEA NUMBER (If known)
LTC/05	8	BS0750566

l. LICENSING INFORMATION

(1) State of License (Code)	(2) (X one) Active	(2) (X one) Inactive	(3) License Number	(1) State of License (Code)	(2) (X one) Active	(2) (X one) Inactive	(3) License Number
CA	X		GFE 6854				

7. TYPE OF PROVIDER AND SPECIALTY (FIELD OF LICENSURE) (X all that apply)

X a. PHYSICIAN DEGREE — D.O. (020) — X M.D. (010)

(1) Highest Level of Specialization: X (a) Board Certified; (b) Residency Completed; (c) In Residency (015/025); (d) No Residency

(2) Primary Specialty

(a) In Training		(g) Family Practice		(m) Orthopedics		(s) Radiology	
(b) General Medical Officer		(h) Internal Medicine		(n) Pathology		(t) Surgery	
(c) Anesthesiology		(i) Neurology		(o) Pediatrics		(u) Undersea Medicine	
(d) Aviation Medicine		(j) Obstetrics/Gynecology		(p) Physical Medicine		(v) Urology	
(e) Dermatology		(k) Ophthalmology		(q) Preventive Medicine		(w) Other (Specify)	
(f) Emergency Medicine		(l) Otorhinolaryngology	X	(r) Psychiatry			

(3) Board Certification(s): American Board of Otolaryngology

b. DENTIST (030)

(1) Highest Level of Specialization: (a) Board Certified; (b) Residency Completed; (c) In Residency (035); (d) No Residency

(2) Primary Specialty: (a) General Dental Officer; (b) Oral Surgeon; (c) Other (Specify)

(3) Board Certification(s)

NOV 14 1994

c. OTHER PROVIDERS

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(2) Clinical Dietician (200)	(7) Nurse Midwife (120)	(12) Physician Assistant (642)
(3) Clinical Pharmacist (050)	(8) Nurse Practitioner (130)	(13) Podiatrist (350)
(4) Clinical Psychologist (370)	(9) Occupational Therapist (410)	(14) Speech Pathologist (450)
(5) Clinical Social Worker (300)	(10) Optometrist (636)	(15) Registered Nurse (100)

REASON CODES (See Page 2)	REASON CODES (See Page 2)	c. LE ACTION
610-02		
610-80	Quality Assurance Document 10 USC 1102, Unauthorized Disclosure carries $3000 Fine	
☐ NONE	☐ NONE	

d. PRIVILEGES AFFECTED BY THE ACTION
All clinical privileges in Otolaryngology and maxillo-facial surgery ar revoked.

e. OTHER ACTIONS TAKEN (X all that apply)

	(1) Review		(3) Retraining		(5) Separated for Cause		(7) Separated		(9) Retired
	(2) Rehabilitation		(4) On-the-Job		(6) Fired / Terminated		(8) Resigned		(10) Other

9. DOCUMENTATION OF NOTIFICATION

a. NAME OF STATE(S) AND CLEARING HOUSE	b. DATE NOTIFIED (YYMMDD)	a. NAME OF STATE(S) AND CLEARING HOUSE	b. DATE (YYM

10. REMARKS LTC Stemmer's clinical privileges were revoked on 2 November 1994. He was advised, in writing, of this action and his rights to a hearing. This decision was based, in part, on the recommendations of the LRMC Ad H Impaired Provider Sub-Committee.

TRUE CERTIFIED COPIES

BY _____

PREPARED BY:

[redacted]

Chief, Quality Division

11. OTSG INDIVIDUAL SUBMITTING COMPLETED REPORT

a. NAME (Last, First, Middle Initial)	b. TITLE	c. TELEPHONE (Include Area
d. ADDRESS Office of the Surgeon General	e. SIGNATURE	f. DATE SIGNE (YYMMDD)

INSTRUCTIONS

(All other items are self-explanatory.)

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2c. Revision to Action: A new action which is related to and modifies a previously submitted adverse action.

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8a. Privileging Actions-Taken / Reason: This entry is equivalent to NPDB's Adverse Action Classification Code.

HEALTH CARE PROVIDER CLINICAL PRIV. .GES ACTION REPORT

(Shaded areas for OTSG information only.)

1. DATE OF REPORT (YYMMDD)	REPORT CONTROL SYM
94/10/13	

Privacy Assurance Document
10 USC 1102, Unauthorized
Disclosure carries $5000 fine

2. TYPE OF REPORT (X one)

X	a. INITIAL		b. CORRECTION OR ADDITION		c. REVISION TO ACTION		d. VOID PREVIOUS REPORT

3. DATE OF ACTION (YYMMDD): 94/10/12

4. EFFECTIVE DATE OF ACTION (YYMMDD): 94/10/12

5. MEDICAL TREATMENT FACILITY

a. NAME: Landstuhl Regional Medical Center

c. DMIS CODE:

b. ADDRESS (Include Zip Code and Country if not U.S.): ATTN: AEMLA-QA (Cliff Wagner, CPHQ) APO AE 09180-3460

6. PROVIDER INFORMATION

a. NAME (Last, First, Middle Initial, Suffix)	b. SOCIAL SECURITY NUMBER	c. DATE OF BIRTH (YYMMDD)	d. SE
STEMMER, AUGUST L.	[redacted]	[redacted]	M

e. NAME OF PROFESSIONAL SCHOOL ATTENDED: Harvard Medical School — X (1) United States; (2) Foreign

f. DATE GRADUATED (YYMMDD): 55/06/16

g. STATUS (X one): X (1) Army; (2) Navy; (3) Air Fo; (4) PHS; (5) Civilia

h. SOURCE OF ACCESSION (X all that apply)

(1) Military	(2) Civilian
X (a) Volunteer	(a) Civil Service
(b) Armed Forces Health Professional Scholarship Program	(b) Contracted
(c) Uniformed Services University of Health Sciences	(c) Consultant
(d) Ready Reserve of the National Guard or Reserve Components	(d) Foreign National (Local hire)
(e) Other (Specify)	(e) Other (Specify)

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i. PAY GRADE: LTC/05

j. YEARS OF FEDERAL SERVICE: 8

k. FEDERAL DEA NUMBER (If known): BS0750566

l. LICENSING INFORMATION

(1) State of License (Code)	(2) (X one) Active	(2) (X one) Inactive	(3) License Number	(1) State of License (Code)	(2) (X one) Active	(2) (X one) Inactive	(3) License Number
CA	X		GFE 6854				

7. TYPE OF PROVIDER AND SPECIALTY (FIELD OF LICENSURE) (X all that apply)

X a. PHYSICIAN DEGREE — D.O. (020) — X M.D. (010)

(1) Highest Level of Specialization: X (a) Board Certified; (b) Residency Completed; (c) In Residency (015/025); (d) No Residency

(2) Primary Specialty

(a) In Training	(g) Family Practice	(m) Orthopedics	(s) Radiology
(b) General Medical Officer	(h) Internal Medicine	(n) Pathology	(t) Surgery
(c) Anesthesiology	(i) Neurology	(o) Pediatrics	(u) Underseas Medicine
(d) Aviation Medicine	(j) Obstetrics/Gynecology	(p) Physical Medicine	(v) Urology
(e) Dermatology	(k) Ophthalmology	(q) Preventive Medicine	(w) Other (Specify)
(f) Emergency Medicine	X (l) Otorhinolaryngology	(r) Psychiatry	

(3) Board Certification(s): American Board of Otolaryngology

b. DENTIST (030)

(1) Highest Level of Specialization: (a) Board Certified; (b) Residency Completed; (c) In Residency (035); (d) No Residency

(2) Primary Specialty: (a) General Dental Officer; (b) Oral Surgeon; (c) Other (Specify)

(3) Board Certification(s):

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c. OTHER PROVIDERS

(1) Audiologist (400)	(6) Nurse Anesthetist (110)	(11) Physical Therapist (430)
(2) Clinical Dietician (200)	(7) Nurse Midwife (120)	(12) Physician Assistant (642)
(3) Clinical Pharmacist (050)	(8) Nurse Practitioner (130)	(13) Podiatrist (350)
(4) Clinical Psychologist (370)	(9) Occupational Therapist (410)	(14) Speech Pathologist (450)
(5) Clinical Social Worker (300)	(10) Optometrist (636)	(15) Registered Nurse (100)

a. PRIVILEGING ACTIONS TAKEN / REASON CODES (See [illegible] 2)	b. ACTIONS OTHER THAN PRIVILEGING (ADMINISTRATIVE) / REASON C[illegible] (See Page 2)	c. LENGTH OF ACTION (In mont
	Quality Assurance Document	
	10 USC 1102, Unauthorized Disclosure carries $3000	Fine
[X] NONE	[X] NONE	N/A

d. PRIVILEGES AFFECTED BY THE ACTION

Abeyance of clinical privileges in otolaryngology, admission and consultation to ICU pending outcome of informal QA investigation. Investigation to be completed and report made NLT COB 13 Oct 1994

e. OTHER ACTIONS TAKEN (X all that apply)

	(1) Review		(3) Retraining		(5) Separated for Cause		(7) Separated		(9) Retired
	(2) Rehabilitation		(4) On-the-Job		(6) Fired / Terminated		(8) Resigned		(10) Other

9. DOCUMENTATION OF NOTIFICATION

a. NAME OF STATE(S) AND CLEARING HOUSE	b. DATE NOTIFIED (YYMMDD)	a. NAME OF STATE(S) AND CLEARING HOUSE	b. DATE NOTIFIE (YYMMDD)

10. REMARKS

LTC Stemmer's clinical privileges were placed in abeyance on 12 October 1994, pending the outcome of an informal QA investigation into allegations of providing substandard care.

PREPARED BY:

TRUE CERTIFIED COPIES

BY

[redacted]

Chief, Quality Division

11. OTSG INDIVIDUAL SUBMITTING COMPLETED REPORT

a. NAME (Last, First, Middle Initial)	b. TITLE	c. TELEPHONE (Include Area Coc

d. ADDRESS	e. SIGNATURE	f. DATE SIGNED (YYMMDD)
Office of the Surgeon General		

INSTRUCTIONS

(All other items are self-explanatory.)

2b. Correction or Addition: An administrative change intended to supersede or add information to the contents of a current version of a report.

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